

1472

CERTIFICATE OF DEATH

Reg. Dist. No.

01432

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena (Rural)		c. LENGTH OF STAY IN 1b 12 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ritchie Highway		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Amelia Middle Catherine Last Affeldt		4. DATE OF DEATH Month 2/ Day 16/ Year 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/1888
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl Glenzer		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Elizabeth Nevaker, Glen Burnie, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 422.1 DUE TO (b) Cardiac decompensation Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) Atherosclerotic Cardio-vascular disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized hypertrophic arthritis		INTERVAL BETWEEN ONSET AND DEATH 1-hour 4 years 6 years	
19. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 20, 1950 to Feb. 16, 1958 , that I last saw the deceased alive on Feb. 14, 1958 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. M. McLaughlin M.D.		ADDRESS (Street, city or town, state) Pasadena, Md. DATE SIGNED Feb. 17, 1958	
PHYSICIAN'S NAME (Type) R. M. McLaughlin			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/20/58	22c. NAME OF CEMETERY OR CREMATORY St Johns Church Cem.	22d. LOCATION (City, town, or county) (State) Phieffers Corner, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James H. Kirkley ADDRESS Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR Gregory	24b. REGISTRAR'S SIGNATURE Gregory

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 21 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. [redacted] may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, [redacted] page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1473

CERTIFICATE OF DEATH

01433

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE		Maryland		b. COUNTY		A.A.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS											
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		(b) DUE TO		(c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.															
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)		DATE SIGNED											
PHYSICIAN'S NAME (Type)															
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE									

CERTIFICATE OF DEATH

BUREAU V. 2
FEB 24 1952

RECEIVED

1439

CERTIFICATE OF DEATH

01434

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN TB X Gambrills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. STREET ADDRESS 1 Rutland Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First M Middle BURCH Last BEARD				4. DATE OF DEATH Month FEBRUARY Day 21 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 6, 1885	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Tabacco		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Julian M. Beard				14. MOTHER'S MAIDEN NAME Virginia Phelps			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs Margaret Beard- Wife- same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cobor pneumonia 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial insufficiency DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 490x				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 20, 1958 , to Feb 21 , 1958, that I last saw the deceased alive on Feb. 21 , 1958, and that death occurred at 3:50 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Emily H. Wilson, M.D. M.D.				ADDRESS (Street, city or town, state) Lothian, Maryland DATE SIGNED 2-22-58			
PHYSICIAN'S NAME (Type) Emily Wilson, M.D.				Lothian, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 23, 1958		22c. NAME OF CEMETERY OR CREMATORY Davidsonville Methodist		22d. LOCATION (City, town, or county) (State) Davidsonville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE FEB 25 '58	
24b. REGISTRAR'S SIGNATURE Albert Seach							

MEDICAL CERTIFICATION

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TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

BUREAU V. S.

FEB 25 1933

RECEIVED

CERTIFICATE OF DEATH

01435

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Laurel				c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training Sch., Children's Center				d. STREET ADDRESS #6, 14th Street N.E.			
3. NAME OF DECEASED (Type or print) First Middle Last Michel Henry Bomar				4. DATE OF DEATH Month Day Year February 18, 1958			
5. SEX male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 22, 1956	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lucius Bomar				14. MOTHER'S MAIDEN NAME Celia Fox Bomar			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Children's Center		Address Laurel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 752x IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration DUE TO (c) Congenital Hydrocephalus							INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Jan. 17, 1958 , to Feb. 18, 1958 , that I last saw the deceased alive on Feb. 18, 1958 , and that death occurred at 5:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wilfred R. Ehrmantraut		ADDRESS (Street, city or town, state) Children's Center, Laurel, Md.		DATE SIGNED 2/19/58			
PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D.		CHILDREN'S CENTER, LAUREL, MD.		2/19/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-21-58		22c. NAME OF CEMETERY OR CREMATORY D.T.S. Cemetery		22d. LOCATION (City, town, or county) (State) Laurel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Thomas, Jr., Laurel, Md.		ADDRESS D.T.S. Cemetery		24a. REC'D BY REGISTRAR DATE FEB 24 '58		24b. REGISTRAR'S SIGNATURE Overman	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FEB 24 1958

RECEIVED

BUREAU V. L.

1475
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Odenton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Odenton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington + Pine</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lucy</i> Middle <i>C.</i> Last <i>Brady</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>7</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 1, 1869</i>
9. AGE (In years last birthday) <i>88</i> yrs.		10. IF UNDER 1 YEAR: Months <i>88</i> Days <i>88</i> Hours <i>88</i> Min. <i>88</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Calvert Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Smith</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>(If yes, give war or dates of service)</i>	
17. INFORMANT <i>Mrs. Eva C. Stallings</i>		Address <i>#2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 6-58</i> to <i>Feb 7-58</i> , that I last saw the deceased alive on <i>Feb 6-58</i> , 19 <i>58</i> , and that death occurred at <i>3A</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph Lipskey</i> M.D.		ADDRESS (Street, city or town, state) <i>Annapolis Md</i>	
PHYSICIAN'S NAME (Type) DR. JOSEPH LIPSKEY		DATE SIGNED <i>Feb 7-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-9-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR <i>Feb 10 58</i>		24b. REGISTRAR'S SIGNATURE <i>W. M. M. M.</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 10 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1476

CERTIFICATE OF DEATH

01437

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raynor Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raynor Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Nursery Road		d. STREET ADDRESS Nursery Road	
3. NAME OF DECEASED (Type or print) First Helen Middle May Last Bremer		4. DATE OF DEATH Month Feb. Day 20 Year 1958	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1884
9. AGE (In years and birthday) 73		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None c	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Edward Bremer		Address Same	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardio-vascular Disease MI DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial asthma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1936 to 2/20 , 19 58 , that I last saw the deceased alive on 2/20/58 , 19 58 , and that death occurred at 8 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 203 W. Maple Road DATE SIGNED Feb. 21, 1958			
ACTUAL SIGNATURE Chas. L. Ball Jr. M.D.		23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Ball Jr. M.D.	
PHYSICIAN'S NAME (Type) Charles L. Ball Jr. M.D.		Linthicum, A. A. Co., Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 22, 1958	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Ritchie Hwy. A. A. Co., Md.	
24a. REC'D BY REGISTRAR EB 25 58		24b. REGISTRAR'S SIGNATURE Edwards	
24c. DATE 4001 Ritchie Hwy.			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

3 15 1958

100-100000

1440

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>a a.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. A. General Hosp</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St Margarets</i>	
f. STREET ADDRESS <i>Annapolis P. O. Box</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>Hoffman</i> Last <i>Brice</i>		4. DATE OF DEATH Month <i>2</i> - Day <i>14</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Aug 15 - 1906</i>
9. AGE (In years last birthday) <i>51</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk (Ret)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U. S. Government</i>	
11. BIRTHPLACE (State or foreign country) <i>St Margarets Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>C. Carroll Brice</i>		14. MOTHER'S MAIDEN NAME <i>Mary Lydings</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>-</i>	
17. INFORMANT <i>Mrs Carlton Waring</i>		18. ADDRESS <i>1488 Reservoir St Annapolis Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Laennec's Cirrhosis</i> DUE TO <i>Hemorrhagic Jaundice</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>-</i> DUE TO (c) <i>-</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>-</i> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-5-58</i> , 19 <i>58</i> , to <i>2-14-58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>2-13-58</i> , 19 <i>58</i> , and that death occurred at <i>7:20 PM</i> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <i>63 College Ave Annapolis Md</i>		DATE SIGNED <i>2-14-58</i>	
ACTUAL SIGNATURE <i>Frank M Shipley</i> M.D.			
PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-16-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm M. Taylor Sons</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 19 1958</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>Redman</i>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 10 1953

RECEIVED

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. Page 6 may be retained by the registrar. After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Filed 2-13-58 et

1441

CERTIFICATE OF DEATH

Reg. Dist. No.

01439

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 16 <u>10</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		d. STREET ADDRESS <u>100 Clay St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>EL</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30, 1893</u>
9. AGE (In years last birthday) <u>64</u> yrs		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chesterfield, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Brown</u>		14. MOTHER'S MAIDEN NAME <u>Martha Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Old. Brown</u>	
17. INFORMANT <u>Old. Brown</u>		Address <u>Annapolis</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Arteriosclerotic Hypertension</u> DUE TO (c) <u>Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 25, 1958</u> to <u>Feb 28, 1958</u> , that I last saw the deceased alive on <u>Feb 28, 1958</u> , and that death occurred at <u>10:15</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richardson</u>		DATE SIGNED <u>3/3/58</u>	
ADDRESS (Street, city or town, state) <u>110-CLAY ST, ANNAPOLIS, MD.</u>			
22a. BURIAL, CREMATION, REMAINS (Specify) <u>Mar 4/58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.B. Johnson</u>		ADDRESS <u>Annapolis</u>	
24a. REC'D BY REGISTRAR <u>Mar 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>John</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7

CERTIFICATE OF DEATH

Reg. Dist. No. 01440

1442

1. PLACE OF DEATH b. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>W. A. General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Daniel</u> First <u>Brown</u> Middle <u>Brown</u> Last				4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-20-1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip Brown</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, and date) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-28-3192</u>		17. INFORMANT <u>Catherine Horsey</u> Address <u>2309 Whittier Ave. Baltimore</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>suicide</u> <u>Anger</u> <u>Tailor</u> <u>795.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>2-22-58</u> to <u>2-27-58</u> , that I last saw the deceased alive on <u>2-27-58</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
MEDICAL SIGNATURE <u>A. T. Allen</u> M. D.				ADDRESS (Street, city or town, state) <u>612 Cathedral Ave. Annapolis, Md</u>			
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>				DATE SIGNED <u>2-27-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-3-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesapeake Chapel</u>		22d. LOCATION (City, town or county) (State) <u>Owensville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>108 Wash St. Annapolis, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Brown</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THOMAS V. M.

1958

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01441**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Same b. COUNTY Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena, Rural Route		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same	
c. LENGTH OF STAY IN 1b Over 15 years		d. STREET ADDRESS Same	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Light Street & Pasadena Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry E. Burch (Harry E. Burck, Jr.)		4. DATE OF DEATH Month Day Year February 13th. 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/92
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Railroad Man., Machinist		10b. KIND OF BUSINESS OR INDUSTRY & O Balto., Maryland	
11. BIRTHPLACE (State or foreign country) Balto., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry E. Lurch Sr.		14. MOTHER'S MAIDEN NAME Lucil Western Hayes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-05-3389	
17. INFORMANT Mr. Georges F. Hayes (Foster brother)		Address (Name)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion +20.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. FUNERAL DIRECTOR'S SIGNATURE <i>G. Howard Evans</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2/13/58	
22b. DATE THEREOF Mon Feb 17 1958		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem., Woodlawn, Balto. Co., Md.	
22d. LOCATION (City, town, or county) (State) Balto. Co., Md.		24a. REC'D BY REGISTRAR FEB 18 '58	
24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

LEONARD V. S.

FEB 1 1911

1911

1478

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 25ys, 3 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS 825 N. Gilmor Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Cephus Last Cephus		4. DATE OF DEATH Month 2 Day 16 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/76
9. AGE (In years last birthday) 81 yrs		IF UNDER 1 YEAR Months 16 Days 19 Hours 58 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Cephus		14. MOTHER'S MAIDEN NAME Martha Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. ----- 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from December 21, 1957 , to February 16, 1958 , that I last saw the deceased alive on February 16, 1958 , and that death occurred at 5:10 A.M. , from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 2/19/58	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 2/27/58	22c. NAME OF CEMETERY OR CREMATORY St. Ann's Church	
22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Bennett</i>		24a. REC'D BY REGISTRAR MAR 4 '58	
ADDRESS 1084 Wash. St. Annapolis, Md.		24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

1959

RECEIVED

BUREAU V. S.

RECEIVED

Item 7 File # 225 2-7-58 et

Reg. Dist. No. _____

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY ANN E ARUNDEL	CITY OR TOWN ANNAPOLIS	COUNTY C. A.	CITY OR TOWN ANNAPOLIS
CITY OR TOWN ANNAPOLIS	LENGTH OF STAY (in this place)	STREET ADDRESS 13 Monument St.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS PLAZA MANOR CONV. HOME			
3. NAME OF DECEASED (Type or Print) JOSEPHINE COATES		4. DATE OF DEATH (Month) (Day) (Year) FEB 2 1958	
5. SEX F	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 1-29-1892
9. AGE last birthday 70 yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Smothers		14. MOTHER'S MAIDEN NAME Elizabeth Smothers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS Richard David Anna, Md.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
231x IMMEDIATE CAUSE (A) Cerebrovascular accident			
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis general			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 1953 to Feb 2 1958 , that I last saw the deceased alive on Jan 30 1958 , and that death occurred at 4:00 A.M. from the causes and on the date stated above.			
SIGNATURE Joseph L. Lee		ADDRESS (Street, city, town, state) M.D. 102 Bx A Blvd. N.E. Glen Burnie, Md. 22	
DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 2-7-58	NAME OF CEMETERY OR CREMATORY St. Andrew Hill	LOCATION (City, town, or county) (State) Annapolis, Md.
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE P. L. Lee	25. FUNERAL DIRECTOR'S SIGNATURE W. H. Lee	ADDRESS Lee, E. - Anna, Md.
DATE FEB 4 58			

INSTRUCTIONS

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The **original** copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the **third copy** of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

U. S. A.

W. A. F. M.

W. A. F. M.

01445

CERTIFICATE OF DEATH

1481

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Glen Burnie</i>		<i>2 yrs</i>		TOWN <i>Glen Burnie</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>207 Ritchie Highway</i>				STREET ADDRESS (If rural give location) <i>207 Ritchie Highway</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Mary</i> (Middle) <i>Jane</i> (Last) <i>Crane</i>				(Month) <i>2</i> (Day) <i>8</i> (Year) <i>19 58</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>white</i>	<i>Widowed</i>	<i>1/19/1879</i>	<i>79</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>house work</i>		<i>at home</i>		<i>Wolford Ireland</i>		<i>U.S.A</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>William Boyce</i>				<i>Budget Kinselle</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<i>Wm William J. Crane 201 St Mc Carley</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Uremia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Nephrosclerosis</i>				<i>9</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Hypertensive Arteriosclerotic Heart Disease</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 5, 19 58</i> , to <i>Feb 3, 19 58</i> , that I last saw the deceased alive on <i>2-7</i> , 19 <i>58</i> , and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<i>Charles R. MacDonald M.D.</i>				<i>P.O. Box 518 Glen Burnie</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>2/12/58</i>		<i>New Catholic Cem.</i>		<i>4300 Old Frederick Rd.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>FEB 10 '58</i>		<i>John J. Cowan</i>		<i>John J. Cowan</i>		<i>901 St</i>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 15M

BUREAU V. S.

FEB 1

RECEIVED

1443

CERTIFICATE OF DEATH

Reg. Dist. No.

01446

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Annapolis General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton, Williamsville, O. d. STREET ADDRESS 1st 2nd St. Direct road	
3. NAME OF DECEASED (Type or print) First Middle Last DAVIS		4. DATE OF DEATH Month Day Year February 6, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1908
9. AGE (In years last birthday) yrs. 50		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Capt. U.S. Army		10b. KIND OF BUSINESS OR INDUSTRY Military	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ralph Davis, Sr.		14. MOTHER'S MAIDEN NAME Lucy Estes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1-10-0-10000	
17. INFORMANT Ralph Davis, Sr.		Address 1st 2nd St. Direct road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1120.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency (c) Atherosclerotic Cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH immediate 3 months 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) X diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1923, to February 6, 1958, that I last saw the deceased alive on February 5, 1958, and that death occurred at 3:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R.M. McLaughlin		M.D. Pasadena, Maryland Feb. 6, 1958	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
	Feb 10/58	1st 2nd St. Direct road	Gordonville, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE R.V. Singleton		ADDRESS Glen Ridge, Md.	
24a. REC'D BY REGISTRAR DATE FEB 10 '58		24b. REGISTRAR'S SIGNATURE R. Search	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director must sign it. The funeral director must sign it. The funeral director must sign it.

TO THE REGISTRAR: The registrar must sign the certificate. The registrar must sign the certificate. The registrar must sign the certificate.

BUREAU V. S.

RECEIVED

14822497-CEE

CERTIFICATE OF DEATH

01447

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Route 2 - Glen Burnie about 5 mi.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie P.O., Pt. Pleasant.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Furnace Drive Box 169A</u>				d. STREET ADDRESS <u>Rural Route 2 - Box 169A</u>			
3. NAME OF DECEASED (Type or print) <u>LENA</u> First <u>Denig</u> Middle Last				4. DATE OF DEATH <u>SUN., FEB. 9, 1958</u> Month Day Year			
5 SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 2, 1878</u>	
9 AGE (in years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT-Home</u>		11. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>(P) POTEN</u>				14. MOTHER'S MAIDEN NAME <u>(P)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>JOHN J. ARMSTRONG - (SAME)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of Lung - 112 x</u> DUE TO (b) <u>Hypertension & Arterio-sclerosis</u> DUE TO (c) <u>10 yrs -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 18, 1957</u> to <u>Feb. 9, 1958</u> , that I last saw the deceased alive on <u>Feb. 9, 1958</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Linthicum, Md.</u>		DATE SIGNED <u>2/10/58</u>	
PHYSICIAN'S NAME (Type) <u>Chas. L. Ball, Jr.</u>				<u>Linthicum, Md.</u>		<u>2/10/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb. 13, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LODI-Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>LODI, New York (Seneca Co)</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Evans</u> ADDRESS <u>14005 CHARLES ST. BALTIMORE</u>				24a. REC'D BY REGISTRAR <u>Feb 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

FEDERAL BUREAU OF INVESTIGATION

NOV 11 1939

RECEIVED

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. Page 6 may be retained by the funeral director. Page 7 may be retained by the funeral director. Page 8 may be retained by the funeral director. Page 9 may be retained by the funeral director. Page 10 may be retained by the funeral director. Page 11 may be retained by the funeral director. Page 12 may be retained by the funeral director. Page 13 may be retained by the funeral director. Page 14 may be retained by the funeral director. Page 15 may be retained by the funeral director. Page 16 may be retained by the funeral director. Page 17 may be retained by the funeral director. Page 18 may be retained by the funeral director. Page 19 may be retained by the funeral director. Page 20 may be retained by the funeral director. Page 21 may be retained by the funeral director. Page 22 may be retained by the funeral director. Page 23 may be retained by the funeral director. Page 24 may be retained by the funeral director. Page 25 may be retained by the funeral director. Page 26 may be retained by the funeral director. Page 27 may be retained by the funeral director. Page 28 may be retained by the funeral director. Page 29 may be retained by the funeral director. Page 30 may be retained by the funeral director. Page 31 may be retained by the funeral director. Page 32 may be retained by the funeral director. Page 33 may be retained by the funeral director. Page 34 may be retained by the funeral director. Page 35 may be retained by the funeral director. Page 36 may be retained by the funeral director. Page 37 may be retained by the funeral director. Page 38 may be retained by the funeral director. Page 39 may be retained by the funeral director. Page 40 may be retained by the funeral director. Page 41 may be retained by the funeral director. Page 42 may be retained by the funeral director. Page 43 may be retained by the funeral director. Page 44 may be retained by the funeral director. Page 45 may be retained by the funeral director. Page 46 may be retained by the funeral director. Page 47 may be retained by the funeral director. Page 48 may be retained by the funeral director. Page 49 may be retained by the funeral director. Page 50 may be retained by the funeral director. Page 51 may be retained by the funeral director. Page 52 may be retained by the funeral director. Page 53 may be retained by the funeral director. Page 54 may be retained by the funeral director. Page 55 may be retained by the funeral director. Page 56 may be retained by the funeral director. Page 57 may be retained by the funeral director. Page 58 may be retained by the funeral director. Page 59 may be retained by the funeral director. Page 60 may be retained by the funeral director. Page 61 may be retained by the funeral director. Page 62 may be retained by the funeral director. Page 63 may be retained by the funeral director. Page 64 may be retained by the funeral director. Page 65 may be retained by the funeral director. Page 66 may be retained by the funeral director. Page 67 may be retained by the funeral director. Page 68 may be retained by the funeral director. Page 69 may be retained by the funeral director. Page 70 may be retained by the funeral director. Page 71 may be retained by the funeral director. Page 72 may be retained by the funeral director. Page 73 may be retained by the funeral director. Page 74 may be retained by the funeral director. Page 75 may be retained by the funeral director. Page 76 may be retained by the funeral director. Page 77 may be retained by the funeral director. Page 78 may be retained by the funeral director. Page 79 may be retained by the funeral director. Page 80 may be retained by the funeral director. Page 81 may be retained by the funeral director. Page 82 may be retained by the funeral director. Page 83 may be retained by the funeral director. Page 84 may be retained by the funeral director. Page 85 may be retained by the funeral director. Page 86 may be retained by the funeral director. Page 87 may be retained by the funeral director. Page 88 may be retained by the funeral director. Page 89 may be retained by the funeral director. Page 90 may be retained by the funeral director. Page 91 may be retained by the funeral director. Page 92 may be retained by the funeral director. Page 93 may be retained by the funeral director. Page 94 may be retained by the funeral director. Page 95 may be retained by the funeral director. Page 96 may be retained by the funeral director. Page 97 may be retained by the funeral director. Page 98 may be retained by the funeral director. Page 99 may be retained by the funeral director. Page 100 may be retained by the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 18 Film 226 3- -58ams Item 16 Film 226 2- -58 et									
1483									
Reg. Dist. No. 27									
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. George G. Meade c. LENGTH OF STAY IN 1b U. S. Army Hospital					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ft. George G. Meade d. STREET ADDRESS 4303 Roberts Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last JEFFERSON R DENNIS					4. DATE OF DEATH Month Day Year February 17 19 58				
5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 April 1909		9. AGE (In years last birthday) yrs 48	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professional Navy Man					10b. KIND OF BUSINESS OR INDUSTRY Colorado			11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Frank L. Dennis					14. MOTHER'S MAIDEN NAME Charlotte Rice				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 561-41-1791				
17. INFORMANT Hospital and personnel Records					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of stomach contents DUE TO Acute coronary insufficiency, with Pulmonary edema DUE TO Coronary artery spasm INTERVAL BETWEEN ONSET AND DEATH Less than 20 minutes 30 minutes 30 minutes				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o p. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 17 February, 1958 , to 17 February 1958 , that I last saw the deceased alive on Dead when first examined , and that death occurred at 1140AM , from the causes and on the date stated above. ADDRESS (Street, city, or town, state) DATE SIGNED ACTUAL SIGNATURE Julian T Harwell M.D. U. S. ARMY HOSPITAL, FT MEADE, MD 17Feb58 PHYSICIAN'S NAME (Type) JULIAN T HARWELL, CAPT U. S. ARMY HOSPITAL, FT MEADE, MD									
22a. BURIAL, CREMATION, or other disposal (Specify) Burial			22b. DATE THEREOF 2/21/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National			22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Carl B. Wolbertson ADDRESS 6306 - Belair Rd - Baltimore - 6 - Md					24a. REC'D BY REGISTRAR DATE 17Feb 58		24b. REGISTRAR'S SIGNATURE CLAUDE D LAUSIER		

BUREAU V. S.

FEB 24 1958

RECEIVED

1184
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE MD- b. COUNTY ANNE ARUNDEL.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAMBRILLS MD.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X GAMBRILLS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle DUNCAN Last DUNCAN				4. DATE OF DEATH Month 2 Day 25 Year 1958.			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-9-1891		9. AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Boston Va.	
13. FATHER'S NAME Lake Duncan				14. MOTHER'S MAIDEN NAME Cora Thelto			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-01-1824		17. INFORMANT Mamie L. Duncan Address B34 Monticello Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Renal insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic glomerular nephritis DUE TO (c) embolism						INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 2/20 , 19 58 , to 2/28 , 19 58 that I last saw the deceased alive on 2/27 , 19 58 , and that death occurred at 6:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 68 Franklin St. - Ga DATE SIGNED 2/26/58							
ACTUAL SIGNATURE Richard A. Guler M.D.				PHYSICIAN'S NAME (Type) Annopolis, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county), (State)	
Burial		3-1-1958		Union Chapel		Harwoodville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Beech ADDRESS #108 Wash. St. Annapolis Md				24a. REC'D BY REGISTRAR DATE FEB 28 '58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 28 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01450

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Res. dencc before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxen Hill, Md.	
c. LENGTH OF STAY IN 1b 45 years		d. STREET ADDRESS 16 X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Last Edelen		4. DATE OF DEATH Month 2 Day 23 Year 19 58	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) yrs 70		10. IF UNDER 1 YEAR Months Days Hours Min 16 X-2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 days 6-10 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 to February 23, 19 58 , that I last saw the deceased alive on February 23, 19 58 , and that death occurred on 10, 15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Ludwig Benedikt		M.D. Crownsville State Hospital, Crownsville, Md.	
PHYSICIAN'S NAME (Type) Ludwig Benedikt		Crownsville, Md. 2/24/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 3.3.58	22c. NAME OF CEMETERY OR CREMATOR U. of Md. Med. School	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE William P. Rossett		24a. REC'D BY REGISTRAR DATE MAR 4 '58	
ADDRESS 108 Wash St. Annapolis, Md.		24b. REGISTRAR'S SIGNATURE Overman	

BUREAU

11/11/11

1486

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A. County		b. STATE Maryland		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Neade		c. LENGTH OF STAY IN 1b 2 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt 2 Box 54-A-		d. STREET ADDRESS Rt 2 Box 54-A Severn Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Perry Middle Elam Last		4. DATE OF DEATH Month 2 Day 14 Year 1958			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 53 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Macon N.C	
13. FATHER'S NAME Rufus Harvey		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs Oglesby Rt- Box 54-A Severn Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident, Massive, Right 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none					INTERVAL BETWEEN ONSET AND DEATH 24 Hours Many years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 15, 1955 to February 15, 1958 , that I last saw the deceased alive on February 15, 1958 , and that death occurred at 2:10 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE E. Podemski Shipley		M.D. 721 Medical Arts Bldg		DATE SIGNED 2-15-58	
PHYSICIAN'S NAME (Type) Baltimore - Maryland #1					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 19, 1958		22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
22d. LOCATION (City, town, or county) Norfolk		22e. (State) Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE ELROY O. WILSON FUNERAL HOME 1000 Brantley Ave.		ADDRESS		24b. REGISTRAR'S SIGNATURE 2-15-58	
24a. REC'D BY REGISTRAR DATE FEB 27 1958					

TURNER V. S.

FEB

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Laurel		c. LENGTH OF STAY IN 1b 40 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training School, Children's Center 2115 Oakland Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nathaniel Erkins		4. DATE OF DEATH Month Day Year February 26 19 58	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1944
9. AGE (In years last birthday) 13 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Daniels (Putative)		14. MOTHER'S MAIDEN NAME Pearl Erkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) --		16. SOCIAL SECURITY NO --	
17. INFORMANT Address Social Service, Children's Center, Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Vomiting and aspiration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Convulsive disorder (c) Cerebral agenesis			INTERVAL BETWEEN ONSET AND DEATH From birth
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Spastic quadriplegia with severe mental retardation			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --
20f. (City or town) --		(County) (State)	
21. I certify that I attended the deceased from January 17, 1958 , to February 26, 1958 , that I last saw the deceased alive on February 26, 1958 , and that death occurred at 12:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wilfred R. Ehrmantraut		ADDRESS (Street, city or town, state) Children's Center, Laurel, Md.	
PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D.		DATE SIGNED 2/26/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2-26-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Va		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Ch...		24a. REC'D BY REGISTRAR DATE FEB 28 '58	
24b. REGISTRAR'S SIGNATURE ...			

TO HOSPITAL OR FUNERAL HOME: This law requires that the death certificate be executed within 24 hours of death. Page 4

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 28 1933

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

01453

1. PLACE OF DEATH o COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hosp.		d. STREET ADDRESS 2207 Homewood Ave.	
3. NAME OF DECEASED (Type or print) First THOMAS Middle L. Last FALLON		4. DATE OF DEATH Month February Day 26 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1879
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Dept. (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank Fallon		14. MOTHER'S MAIDEN NAME Catherine Grogan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 212-03-6306	
17. INFORMANT Mrs. Harlan W. Hooe, Jr.		Address Raleigh, N. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 446 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis with nephrosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1-2 wks 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1 , 19 58 , to Feb 26 , 19 58 , that I last saw the deceased alive on Feb 26 , 19 58 , and that death occurred at 10:30 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE John L. Hederman		ADDRESS (Street, city or town, state) 68 Frevelin St. Annapolis, Md	
PHYSICIAN'S NAME (Type) Annapolis, Md		DATE SIGNED 2/27/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 1, 1958	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Tiekner		24a. REC'D BY REGISTRAR FEB 28 1958	
ADDRESS 9400 17th		24b. REGISTRAR'S SIGNATURE W. J. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A. 1911

1911



1445

CERTIFICATE OF DEATH

Reg. Dist. No.

01454

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 8 Wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis		d. STREET ADDRESS 1926 West Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William		First Edward		Middle Fletcher		Last	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-22-1866	
9. AGE (In years last birthday) yrs. 91 1/2		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Navy Veteran		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Prince George Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Mary Scott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Spanish-American-W.W.I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Charles W. Fletcher-1009 Wheeler Ave. Balt. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332X DUE TO Cerebral Thromboses Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-4-58 19 to 2-26-58 19 that I last saw the deceased alive on 2-26-58 19 and that death occurred at 7:58 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cathedral Street Annapolis, Md. DATE SIGNED A. T. Allen							
ACTUAL SIGNATURE A. T. Allen		M.D. C. L. Crookshank					
PHYSICIAN'S NAME (Type) A. T. Allen		Cathedral Street-Annapolis, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-2-58		22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III				ADDRESS Annapolis Md.		24a. REC'D BY REGISTRAR DATE MAR 5 '58	
				24b. REGISTRAR'S SIGNATURE [Signature]			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the necessary information prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

U.S. AIR FORCE

100-100000

100-100000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01455

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS 1109 West Leigh Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Plaza Manor Nursing Home		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		4. DATE OF DEATH 2-17-58	
5. SEX M		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 10, 1902	
9. AGE (in years last birthday) 56 yrs		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Richmond Va		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Corrie Lee Fox		14. MOTHER'S MAIDEN NAME Lelia Carter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT William Fox, 1409 Leigh St Richmond-Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure - To Cold DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) FOUND DEAD IN SNOW BANK	
20c. TIME OF INJURY Month, Day, Year 2/17 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard Nursing Home		20f. (City or town) Glen Burnie-AA-MO (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.S. FISHER		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R.S. FISHER		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/18/58	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 2-21-58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) Balto. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law-802 Madison Ave.		ADDRESS	
24a. REC'D BY REGISTRAR Feb 21 1958		24b. REGISTRAR'S SIGNATURE Dr. J. Smith	

RECEIVED
U. S.

FEB

1951

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01456

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>4th NE ARVDEL</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>✓</u>	
CITY OR TOWN <u>elen Burnie</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Balto.</u>		20	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Plaza Manor Court House</u>				STREET ADDRESS <u>2422 BRENTWOOD AVE</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Anna</u> (Middle) <u>(ANNIE)</u> (Last) <u>FRAZIER</u>				(Month) <u>Feb</u> (Day) <u>20</u> (Year) <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1-5-1893</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Private Family</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Accomac Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Sabra Polson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT & ADDRESS <u>Ardella Frazier - 2408 Brentwood Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebro-vascular accident</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROSIS General</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 6</u> , 19 <u>58</u> , to <u>Feb 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-15</u> , 19 <u>58</u> , and that death occurred at <u>2:15</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>M.D. ARBNA Blvd. B.E. Cheltenham, Md. 2-20-58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/24/58</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		ADDRESS <u>802 Mad. Ave.</u>	
DATE <u>FEB 25 '58</u>							

ELIZABETH V. S.

1875

1875

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1446

Reg. Dist. No.

01457

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AA General</u>				d. STREET ADDRESS <u>Annapolis Md</u>			
3. NAME OF DECEASED (Type or print) First <u>Frederick L. J.</u> Middle <u>Gelhaus</u> Last <u></u>				4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>1-27-1891</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D. A. V.</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Frederick L. J. Gelhaus</u>				14. MOTHER'S MAIDEN NAME <u>Antoinette Rehn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>World War I WW I</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Frederick L. Gelhaus</u> Address <u>(2)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden disease</u> DUE TO <u>44</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO <u></u> (b) <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u></u> 19 <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-22-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Esq</u>				24a. REC'D BY REGISTRAR <u>Feb 24 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. median</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JOHN A. B.

FB 01 1958

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1490

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTO Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 214 CAARENDON AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) BESSIE First Middle V Last GORMLEY				4. DATE OF DEATH FEB Month 22 Day 1958 Year			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 21 1884	9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.		11. IF UNDER 24 HRS: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JAMES WILSON				14. MOTHER'S MAIDEN NAME MARY ALLENDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT WALTER E. GORMLEY		Address PASADENA, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH 5 HOURS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from FEB 19 , 19 58 , to FEB 22 , 19 58 , that I last saw the deceased alive on FEB 19 , 19 58 , and that death occurred at 6 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mountain Rd. Pasadena, Md. DATE SIGNED ACTUAL SIGNATURE Arthur Lankford Jr. M.D. Arthur Lankford Jr. PHYSICIAN'S NAME (Type) ARTHUR LANKFORD JR. PASADENA, MARYLAND.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-26-58		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Governor Ritchie Highway	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. RECEIVED BY REGISTRAR FEB 27 '58		24b. REGISTRAR'S SIGNATURE W. Lankford	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

8201 - 108

RECEIVED
MAY 1961

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1491

CERTIFICATE OF DEATH

Reg. Dist. No. 1459

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>11</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Douglas Rd #5</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Terrace Gardens Arnold</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Terrace Gardens Arnold</u>				d. STREET ADDRESS <u># 5 Piquet Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emilia Merchant Graves</u>				4. DATE OF DEATH Month Day Year <u>2-21-1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 26, 1890</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cordova Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James F. Godwin</u>				14. MOTHER'S MAIDEN NAME <u>Anna Merchant</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>MRS. Ethel Zimmerman, Same as 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. Disease</u> DUE TO (c) <u>Diabetes Mellitus</u> <u>Gen. Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>12-5-57</u> , 19 <u>57</u> , to <u>1-21-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-5-57</u> , 19 <u>57</u> , and that death occurred at <u>21</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D. <u>Severna Park Md 2-21-58</u> PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u> <u>Severna Park Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping + Kirker</u>			24a. REC'D BY REGISTRAR DATE <u>FEB 24 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Elmer</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

78 1 1 1958

RECEIVED

1447 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. HOSPITAL</u>		d. STREET ADDRESS <u>620 Chesapeake St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANGUS McDONALD GREEN</u>		4. DATE OF DEATH Month Day Year <u>2-23 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 1904</u>
9. AGE (In years last birthday) <u>53</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES W. GREEN</u>		14. MOTHER'S MAIDEN NAME <u>HANNA LOCKE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JAMES GREEN</u>		Address <u>Culpeper, VA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of middle cerebral artery</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-23-1958</u> to <u>2-23-1958</u> that I last saw the deceased alive on <u>2-23-1958</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>63 College Ave. Culpeper, VA</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		DATE SIGNED <u>2-23-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-25-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Culpeper VA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clare Funeral Home</u>		ADDRESS <u>Culpeper, VA</u>	
24a. REC'D BY REGISTRAR <u>W. B. Beach</u>		24b. REGISTRAR'S SIGNATURE <u>W. B. Beach</u>	
DATE <u>FEB 25 '58</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at a hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at a hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB

1911

1448

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospt.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenwood Acres</u>	
		d. STREET ADDRESS <u>108 Second St.</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>O.</u> Last <u>Greene</u>		4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-18-1911</u>
9. AGE (In years last birthday) <u>46</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Greene</u>		14. MOTHER'S MAIDEN NAME <u>Alice Shreve</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year of discharge or service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Anne Smith Greene</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>5 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1956</u> , to <u>2-13-1958</u> , that I last saw the deceased alive on <u>2-13-1958</u> , and that death occurred at <u>7:58 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>13 College Ave</u> DATE SIGNED <u>2-13-58</u>	
PRINTED NAME (Type) <u>Frank M. Shipley</u>		<u>Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-16-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Huntington W. Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>FEB 19 '58</u>		<u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 4 1953

BUREAU V. E.

1449

CERTIFICATE OF DEATH

01462
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hosp</u>		d. STREET ADDRESS <u>1950 A West St.</u>	
3. NAME OF <u>Martha</u> <u>Harried</u> (Type or print) First Middle Last		4. DATE OF DEATH Month <u>2</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cal</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Durham, N.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Jones</u>		14. MOTHER'S MAIDEN NAME <u>Florence Hunt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-3-58</u> 19 _____, to <u>2-28-58</u> 19 _____, that I last saw the deceased alive on <u>2-27-58</u> , 19 _____, and that death occurred at <u>12 P.</u> M. from the causes and on the date stated above.			
DECEASED'S SIGNATURE <u>A. T. Allen</u>		DATE SIGNED <u>2-28-58</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>3-3-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belleville</u>	22d. LOCATION (City, town, or county) (State) <u>Belleville Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		ADDRESS <u>Anna, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Allen</u>	

TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

U. S. A.

1958

APR 1958

1492 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.				c. LENGTH OF STAY IN TB 7 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings				d. STREET ADDRESS None			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rufus Middle James Last Hawkins				4. DATE OF DEATH Month 2 Day 20 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> , DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 5/10/1905	
9. AGE (In years last birthday) 52 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-22-1220		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Disease X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Syphilis DUE TO (c) -----				INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Deterioration				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from February 13, 19 58 to February 20, 19 58 , that I last saw the deceased alive on February 20, 19 58 , and that death occurred at 1:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Hildegard Heard Reissmann				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 2/21/58	
PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D.				Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 2/23/58		22b. DATE THEREOF 2/23/58		22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or county) (State) Lower Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Sewell				ADDRESS Prince Frederick, Md.		24a. REC'D BY REGISTRAR DATE FEB 26 1959	
24b. REGISTRAR'S SIGNATURE W. H. H. H.							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

BUREAU V. B.

FEB 28 1953

RECEIVED

1493 CERTIFICATE OF DEATH

01464

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) d. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PASADENA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PASADENA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RIVEIRA BEACH		d. STREET ADDRESS RIVERA BEACH	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM JOSEPH HENTHORN		4. DATE OF DEATH Month Day Year FEB 6 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 10 1968
9. AGE (In years last birthday) yrs. 29		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST	
10b. KIND OF BUSINESS OR INDUSTRY PAV ROADS		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME THOMAS HENTHORNE		14. MOTHER'S MAIDEN NAME MARY JANE MOFFET	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT KATHERINE HOPKINS		Address 71 London Ave BALTO. MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASC. HEART DISEASE 422.1 DUE TO (b) HEPATIC INSUFFICIENCY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) SENILITY (CAACHEXIA) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 1 1/2 YRS 6 MO.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from FEB 6 1958 to Feb 6 1958 , that I last saw the deceased alive on NEVER SAW ALIVE 19, and that death occurred at 4:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur Lankford Jr		ADDRESS (Street, city or town, state) DATE SIGNED M.D. Mountain Rd. Pasadena, Md.	
PHYSICIAN'S NAME (Type) ARTHUR LANKFORD JR		PASADENA, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Feb-10-1958	Mr. Dewet	Balto Md
23. FUNERAL DIRECTOR'S SIGNATURE John F. Dewfel		ADDRESS 5311 Edmondson Ave	
24a. REC'D BY REGISTRAR DATE FEB 10 '58		24b. REGISTRAR'S SIGNATURE DeWet	

TO HOSPITAL OR TO FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the funeral director, and after this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

1450

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater, Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater,	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Anne Arundel General Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Fulton Herbert		4. DATE OF DEATH Month Day Year 2 3 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/27/58
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi driver		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Elijah Herbert		14. MOTHER'S MAIDEN NAME Margaret Rice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Leukemia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Kimmel Steel - Wilson Syndrome</i> DUE TO (c) <i>Diabetes M.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetic Coma</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953, to 2/31, 1958, that I last saw the deceased alive on 2-3-58, 19, and that death occurred at 7:15 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Frank M. Shipley</i> M.D. <i>63 College Ave</i>			
PHYSICIAN'S NAME (Type) Frank M. Shipley, M.D.		<i>Annapolis, Md 2-3-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-6-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>148 Wash St. Annapolis</i>		24a. REC'D BY REGISTRAR DATE FEB 10 '58	
24b. REGISTRAR'S SIGNATURE <i>W. Deane</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PORTLAND V. S.

PLATE 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1451

Item 9 Willm 226 2-28-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

01466

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville	
c. LENGTH OF STAY IN 1b 24 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS Rural	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ninnie Middle (none) Last HERRELL		4. DATE OF DEATH Month February Day 21 Year 1958	
5. SEX Female	6. COLOR OR <input checked="" type="checkbox"/> White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1892
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Robert P. Herrall - Son -		Address Millersville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of cervix with generalized metastases DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 29 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September, 1955 , to Feb. 21, 1958 , that I last saw the deceased alive on Feb. 21, 1958 , and that death occurred at 2:30A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edith Rodler		ADDRESS (Street, city or town, state) 45 Franklin St.	
PHYSICIAN'S NAME (Type) Dr. Edith Rodler		DATE SIGNED 2/21/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		22b. DATE THEREOF 2-21-58	
22c. NAME OF CEMETERY OR CREMATORY Harrell Cemetery		22d. LOCATION (City, town, or county) (State) Nr Tazewell, Claiborne Co, Tenn	
23. FUNERAL DIRECTOR'S SIGNATURE HOPKINS FUNERAL HOME		ADDRESS ANNAPOLIS, MD.	
24a. REC'D BY REGISTRAR DATE FEB 25 58		24b. REGISTRAR'S SIGNATURE Edith Rodler	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6 1

EDWARD V. S.

F.B.

1961

CERTIFICATE OF DEATH

Reg. Dist. No. 23-

1 PLACE OF DEATH a. COUNTY <i>Dundee Glen Burnie</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Dundee Glen Burnie</i> b. COUNTY <i>G. D. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie Md</i>		c. LENGTH OF STAY IN 1b <i>35 years.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie Md</i>	
3 NAME OF DECEASED (Type or print) First <i>Gladys</i> Middle <i>Walgatta</i> Last <i>Holland</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>4</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 2, 1888</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>
13. FATHER'S NAME <i>William K. Duncan</i>		14. MOTHER'S MAIDEN NAME <i>Elyse Reilly</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs. William Clark</i> Address <i>Same</i>
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute virus infection</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Valvular Disease of the Heart.</i> DUE TO (c) <i>Diabetes.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 days.</i> <i>15 years</i> <i>15 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>Feb 3, 1958</i> , to <i>Feb 4, 1958</i> , that I last saw the deceased alive on <i>Feb 3, 1958</i> , and that death occurred at <i>1 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>James S. Beckinghaus M.D.</i>		M.D. <i>106 Central Ave. Glen Burnie Md. Feb 4, 1958</i>	
PHYSICIAN'S NAME (Type) <i>James S. Beckinghaus M.D.</i>		<i>106 Central Ave. Glen Burnie Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Feb 7, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Fort Myer, Virginia</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard V. Singleton</i>		ADDRESS <i>Glen Burnie, Md.</i>	
24a. REC'D BY REGISTRAR <i>Feb 10 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Robert E. Smith</i>	

BUREAU V. S.

FEB 1 1900

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the funeral home prior to burial, cremation, or removal, and in any event within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1495

CERTIFICATE OF DEATH

01468

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived or institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401-4</u>	
c. LENGTH OF STAY IN 1b <u>7ys, 8mos, 2ds</u>		d. STREET ADDRESS <u>Unknown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Holley</u> Last <u>Holley</u>		4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>71?</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal Hemorrhage</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Psychosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 24, 19 58</u> , to <u>February 25, 19 58</u> , that I last saw the deceased alive on <u>February 25, 19 58</u> and that death occurred at <u>2:30 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>2/25/58</u> ACTUAL SIGNATURE <u>Hildegard Heard Reissmann</u> M.D. PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissmann, M. D., Crownsville State Hospital, Md.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>		22d. LOCATION (City, town, or county) (State) <u>19 S. Greene St. Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Bennett</u>		24. REC'D BY REGISTRAR DATE <u>MAR 6 '58</u>	
25. REGISTRAR'S SIGNATURE <u> </u>		26. REGISTRAR'S SIGNATURE <u> </u>	

BUREAU V. S.

MAR 6 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1496

CERTIFICATE OF DEATH

01469

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Severna Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ritchie Highway</u>		d. STREET ADDRESS <u>1 Ritchie Highway</u>	
3. NAME OF DECEASED (Type or print) <u>John Edgar Hood</u> First Middle Last		4. DATE OF DEATH <u>Feb 10</u> 19 <u>58</u> Month Day Year	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 12 1893</u> 64 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Office Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David C Hood</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Kaltenbach</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>111-111111</u>	
17. INFORMANT <u>Wife (Mamie Hood)</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial INFARCTION</u>			
422.1 DUE TO <u>Coronary Atherosclerosis</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Heart</u>			
(c) <u>Heart</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1954</u> 19 to <u>1958</u> 19 that I last saw the deceased alive on <u>2-9-58</u> 19, and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park 21018</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		DATE SIGNED <u>Feb 12 2-10-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>Feb 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Singleton</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 3

RECEIVED

CERTIFICATE OF DEATH

01470
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel County</i> <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glennburnie Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glennburnie a a Co Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Samuel</i> <i>Howard</i>		4. DATE OF DEATH Month Day Year <i>7</i> <i>2</i> <i>1958</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>e</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/28/1903</i>
9. AGE (In years last birthday) <i>54</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William Howard</i>		14. MOTHER'S MAIDEN NAME <i>Frances Helen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Samuel Howard L. Freiler a a Co</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i> 41 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardio-vascular disease</i> DUE TO (c) <i>generalized arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>4 years</i> <i>unknown</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>January 14, 1953</i> , to <i>February 2, 1958</i> , that I last saw the deceased alive on <i>February 1, 1958</i> , and that death occurred at <i>7:40 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>		ADDRESS (Street, city or town, state) <i>Pasadena, Md.</i> DATE SIGNED <i>Feb. 3, 1958</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>2-1-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Marble Hill</i>		22d. LOCATION (City, town, or county) (State) <i>a a Co., Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Z. Brown Jr</i>		ADDRESS <i>108 W. Montgomery St.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Anderson</i>	
DATE <i>Feb 7 '58</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained in the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained in the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained in the hospital or attending physician.

BUREAU V. 3

FEB 7 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1498 am 2 Feb 23 3-17-58
CERTIFICATE OF DEATH

01471

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u> c. LENGTH OF STAY IN lb <u>11mo, 23da.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil County</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, Md. Baltimore</u> d. STREET ADDRESS <u>Waverly Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Howard</u> Last <u>Howard</u>		4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years lost birthday) <u>81?</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Worker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>
11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Abram Howard</u>		14. MOTHER'S MAIDEN NAME <u>Lillian</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Cancer of the Prostata Glands</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 17, 1957</u> , to <u>February 9, 1958</u> , that I last saw the deceased alive on <u>February 9, 1958</u> , and that death occurred at <u>9:10AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>2/10/58</u> ACTUAL SIGNATURE <u>Hildegard Heard Reissmann</u> MD PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissmann, M. D.</u> <u>Crownsville State Hospital, Md.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Removed</u>		22b. DATE THEREOF <u>2-11-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Not used</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reiss #108 Wash St. Anna, Md.</u>		24. REC'D BY REGISTRAR <u>Feb 14 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 1958
BUREAU V. S.

1499

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>30 Pleasant</i>		c. LENGTH OF STAY IN 1b <i>18 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William</i> First <i>Chelmond</i> Middle <i>Chelmond</i> Last		4. DATE OF DEATH <i>Feb.</i> Month <i>15</i> Day <i>1958</i> Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 11 1891</i>
9. AGE (In years last birthday) <i>66 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>11</i> Days <i>11</i> Hours <i>11</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>St. Margarets</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Chelmond</i>		14. MOTHER'S MAIDEN NAME <i>Bettie (unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Joseph Chelmond</i> Address <i>St. Margarets</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i>			
4-0-1 DUE TO (b) <i>Arteriosclerotic Hypertension</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Cardiovascular disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 24, 1958</i> to <i>Feb 15, 1958</i> , that I lost saw the deceased alive on <i>Feb 13, 1958</i> , and that death occurred at <i>11:00 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. L. Richardson</i>		DATE SIGNED <i>Feb 15 1958</i>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Johnson</i> ADDRESS <i>Annapolis, Md.</i>		24a. REC'D BY REGISTRAR <i>Feb 21 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>W. H. Lewis</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED V. S.

FEB 1963

1963

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01473

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> COUNTY <i>a. a. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. LENGTH OF STAY IN 1b <i>Annapolis Md</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>DoA-Anne Arundel General</i>		e. STREET ADDRESS <i>Annapolis Md</i>	
3. NAME OF DECEASED (Type or print) <i>CAROLINE A JACOBS</i>		4. DATE OF DEATH Month <i>2</i> - Day <i>15</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-20-1957</i>
9. AGE (In years last birthday) <i>6</i> yrs		10. IF UNDER 1 YEAR F UNDER 24 HRS. Months <i>6</i> Days <i>6</i> Hours <i>11</i> M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph a. Jacobs Jr.</i>		14. MOTHER'S MAIDEN NAME <i>Alice Booth</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Alice Jacobs</i>		Address <i>144 Cherry Ct.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE PURULENT OTITIS MEDIA</i> <i>392.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>392.0</i> (c), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Russell S Fisher</i> M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Russell S Fisher</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-21-1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese #108101 St. Anna Md</i>		24a. REC'D BY REGISTRAR <i>2/15/58</i>	
24b. REGISTRAR'S SIGNATURE <i>2/15/58</i>		DATE <i>FEB 27 '58</i>	

RECEIVED
FEB 11 1968
BUREAU OF A. S.

CERTIFICATE OF DEATH

01474

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>		c. LENGTH OF STAY IN 1b <u>11</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mulberry Hill A. A. Co.</u>		d. STREET ADDRESS <u>Mulberry Hill Md</u>	
3. NAME OF DECEASED (Type or print) <u>Benjamin</u> First <u>Johnson</u> Middle <u>John</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-6-1886</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Pension (U.S.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elijah Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Harett Kimball</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> No, <input type="checkbox"/> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>5233</u>	
17. INFORMANT <u>Ella Johnson</u> Address <u>Mulberry Hill Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>5233</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic</u> DUE TO (c) <u>bronchitis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-30-57</u> , 19 <u>57</u> , to <u>2-9-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-8-58</u> , 19 <u>58</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u>		DATE SIGNED <u>2-11-58</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-12-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Broadneck Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beece</u> ADDRESS <u>#108 North St Annapolis</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 20 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be delivered to the funeral director. Pages 1 and 2 should be filed with the funeral director. The funeral director should be notified of the death within 72 hours after death.

BUREAU V. S.

FF3

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01475

1500

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. LENGTH OF STAY IN 1b <u>Over 20 years</u> d. CITY OR TOWN (f outside corporate limits, write RURAL and give nearest town) <u>ame</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Queenstown Rd.</u>		e. STREET ADDRESS <u>Same</u>	
3. NAME OF DECEASED (Type or print) <u>Priestly Johnson</u>		4. DATE OF DEATH <u>February 11th</u> <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/30/1888</u>
9. AGE (in years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>South Carolina</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Neomi Carter</u>		Address <u>1140 Argyle Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>General Arteriosclerosis and exposure to cold weather.</u> 450.0 DUE TO <u>cold weather.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2/12/58</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Rice</u>		ADDRESS <u>661 W. Barra Street</u>	
24a. REC'D BY REGISTRAR <u>DATE FEB 1 1958</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

ESCHAU V. S.

FEB 14 1903

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01476

Reg. Dist. No.

1501

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Feddersburg</u>	
c. LENGTH OF STAY IN 1b <u>1mo., 4 days</u>		d. STREET ADDRESS <u>Reliance Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Johnson</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>90?</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Steven Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Emily</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>-----</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Disease</u> <u>023X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C. N. S. Syphilis</u> DUE TO (c) <u>-----</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State) <u>-----</u>	
21. I certify that I attended the deceased from <u>January 23</u> , 19 <u>58</u> , to <u>February 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>February 27</u> , 19 <u>58</u> , and that death occurred at <u>2:40 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>2/28/58</u>			
ACTUAL SIGNATURE <u>Hildegard Heard Reissmann</u>			
PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissmann, M. D. Crownsville State Hospital, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed 3/4/58</u>		22b. NAME OF CEMETERY OR CREMATORY <u>4. of Md. Med. School</u>	
22c. LOCATION (City, town, or county) (State) <u>29 S. Green St. Balt. Md.</u>		22d. LOCATION (City, town, or county) (State) <u>29 S. Green St. Balt. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William R. ...</u>		24a. REC'D BY REGISTRAR <u>-----</u>	
24b. REGISTRAR'S SIGNATURE <u>-----</u>		24c. DATE <u>MAR 6 '58</u>	

BUREAU V. S.

MAR 6 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1454

CERTIFICATE OF DEATH

01477

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. STREET ADDRESS Spa Road		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last JOHN A KIMBALL SR.		4. DATE OF DEATH Month Day Year February 13 19 58							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1894	9. AGE (in years last birthday) 63 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber-ret		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Simon Kimball		14. MOTHER'S MAIDEN NAME Mary E. Lamb							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-18-6502		17. INFORMANT Mrs Louise S. Kimbill		Address Wife same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION & MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE DUE TO (c) 10 YRS								INTERVAL BETWEEN ONSET AND DEATH 8 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Annapolis		(County) (State)	
21. I certify that I attended the deceased from JUNE 1954 , to 13 FEB 1958 , that I last saw the deceased alive on 13 FEB 1958 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 41 Southgate Ave. Annapolis, Maryland DATE SIGNED 2/14/58									
ACTUAL SIGNATURE Edward S. Back		M.D.							
PHYSICIAN'S NAME (Type) Edward S. Back									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 15, 58		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) Annapolis, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR FEB 18 58		24b. REGISTRAR'S SIGNATURE W. H. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 18 1953

U.S. DEPT. OF JUSTICE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or other disposition.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01478

1. PLACE OF DEATH a. COUNTY <u>HUNNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.Co.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>A.A. GENERAL Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS SAMUEL KOLBE</u>		4. DATE OF DEATH Month Day Year <u>2 18 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-1957</u>
9. AGE (in years last birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		11d. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES S. KOLBE JR.</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA LEE JOHNSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>JAMES S. KOLBE</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>924.0 asphyxia</u> DUE TO (b) <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost, DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Chin face down in creek at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>2/18/58</u> 19 p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Arco Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Okurbaat</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. L. W. H. E. D. T.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/18/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/22/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. ANNE'S CEMETARY</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. G. L. O. S. S. S.</u>		24a. REC'D BY REGISTRAR <u>—</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>FEB 24 '58</u>			

BUREAU V. S.

FEB 14 1953

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Pa. 25-2-2-5

01479

1502

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNAP Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>NEW Jersey</u> b. COUNTY <u>Bergen</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park (County)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rivervale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>103-7-1 Ave Balto. 25</u>		d. STREET ADDRESS <u>534 Rivervale Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Evlyn</u> Middle <u>Bornice</u> Last <u>Koppel</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-17</u>
9. AGE (In years last birthday) <u>41</u> yrs		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> IF UNDER 24 HRS: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SIMON Barry Glass</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Glass</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Richard Koppel - same</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170x</u> DUE TO (b) <u>acute Heart Failure</u> DUE TO (c) <u>Carcinoma of Breast (Bilateral)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u> <u>3 1/2 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 15, 1954</u> to <u>Feb 14, 1958</u> , that I last saw the deceased alive on <u>Feb 14, 1958</u> , and that death occurred at <u>254 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis J. Glass</u>		ADDRESS (Street, city or town, state) <u>320 Patapsco Ave Balto 25 Md</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS J. Glass MD</u>		DATE SIGNED <u>2/14/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>2-14-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u>		ADDRESS <u>2100 Euteria Place</u>	
24a. REC'D BY REGISTRAR <u>FEB 16 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>	

BUREAU V. S.

EB 12 3

100-0-387-10

1503

CERTIFICATE OF DEATH

Reg. Dist. No.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

VS A15 (4)
15M 9/55

U.S. AIR FORCE

18

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1504

CERTIFICATE OF DEATH

Reg. Dist. No.

01481

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Box 377, Rt. 2, Arnold.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ARNOLD, Maryland</u>		d. STREET ADDRESS <u>—</u> <input checked="" type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stanley W Lerp</u>		4. DATE OF DEATH Month Day Year <u>February 11 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 11-1904</u>
9. AGE (In years last birthday) <u>53 yrs</u>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELEC.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO, MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WALTER LERP</u>		14. MOTHER'S MAIDEN NAME <u>AGNES Rudolph</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach</u> DUE TO <u>151x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(Inoperable)</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 21, 1957</u> , to <u>February 11, 1958</u> , that I last saw the deceased alive on <u>February 10, 1958</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Box 289, Severna Park, Maryland</u> DATE SIGNED <u>2/11/58</u>			
ACTUAL SIGNATURE <u>Francis I. Codd</u> M.D.		DATE SIGNED <u>2/11/58</u>	
PHYSICIAN'S NAME (Type) <u>Francis I. Codd, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-14-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Co.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McGilly Funeral Home</u> ADDRESS <u>130 E Fort Ave</u>		24a. REC'D BY REGISTRAR <u>REC'D 1 4 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. A. Smith</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DECEMBER 11, 1911

FEB 11

RECEIVED
FEB 11 1912

1505

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A. County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> COUNTY <i>A. A. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jacobsville Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jacobsville Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Jacobsville Md.</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>Lewis</i> Last		4. DATE OF DEATH Month <i>2</i> Day <i>13</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-15-1894</i>
9. AGE (In years last birthday) <i>63</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>South Carolina U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>7</i>		14. MOTHER'S MAIDEN NAME <i>7</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>124-03-7237</i>	
17. INFORMANT <i>Elizabeth Lewis Jacobsville Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute pulmonary edema</i>		<i>1 hour</i>	
DUE TO (b) <i>Arteriosclerotic Cardio-vascular disease</i>		<i>3 years</i>	
DUE TO (c) <i>Cardiac decompensation</i>		<i>6 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Cerebro-vascular accident 1953</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 12, 1950</i> , to <i>February 13, 1958</i> , that I last saw the deceased alive on <i>February 12, 1958</i> , and that death occurred at <i>5:00 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. M. McLaughlin</i> M.D.		ADDRESS (Street, city or town, state) <i>Pasadena, Maryland</i> DATE SIGNED <i>Feb 13, 1958</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>2-16-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Beckett, 108 Washington Ave</i>		24a. REC'D BY REGISTRAR <i>Feb 20 58</i> 24b. REGISTRAR'S SIGNATURE <i>W. Beckett</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

EST. 1873

U.S. DEPT. OF JUSTICE

CERTIFICATE OF DEATH

01483

Reg. Dist. No.

1456

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Kentucky</u> b. COUNTY <u>Boyd</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>3 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EMILY</u> Middle <u>S</u> Last <u>LYON</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>21</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 2, 1879</u>	
9. AGE (In years last birthday) <u>78 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>Martha, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u>				16. SOCIAL SECURITY NO <u>404-20-3978B</u>		17. INFORMANT <u>Mr. Alonzo E. Lyon- Husband- same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO (c) <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X DIABETES MELLITUS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>57</u> , to <u>22 FEB. 1958</u> , that I last saw the deceased alive on <u>22 FEB</u> , 19 <u>58</u> , and that death occurred at <u>2:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Southgate Ave. Annapolis, Md.</u> DATE SIGNED <u>Edward S. Beck</u>							
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>REMOVAL * BURIAL</u>		<u>2-22-58</u>		<u>ASHLAND, KENTUCKY</u>		<u>ASHLAND, KENTUCKY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Maryland</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	
DATE <u>FEB 25 '58</u>							

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM V. S.

1958

WILLIAM V. S.

1506

CERTIFICATE OF DEATH

01484

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> <u>Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Severna Park.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. Gen Hosp (not admitted)</u> <u>DOA</u>		d. STREET ADDRESS <u>Md</u>	
3. NAME OF DECEASED (Type or print) <u>William Mathew</u> <u>McPherson</u>		4. DATE OF DEATH <u>2-9-58</u> 19 <u>58</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25th 1901</u>
9. AGE (In years last birthday) <u>56</u> yrs		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POWER PLANT</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel L. McPherson</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Hickemboatom</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(1) yes, give war or dates of service</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Son Howard McPherson</u> # <u>(2)</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO <u>Hypertensive C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> 19 <u>58</u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>1954</u> , 19 <u> </u> , to <u>1958</u> , 19 <u> </u> , that I last saw the deceased alive on <u>2-9-58</u> , 19 <u> </u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. HAHN</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>2-9-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		<u>Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-12-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR <u> </u> ADDRESS <u>Annapolis Md</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		DATE FEB 11 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law also requires that the death certificate be signed by the attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ROBERT J. V. M.

1938

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please e-
 culate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be
 forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation,
 or file with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01485

1457

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) F.A. GENERAL HOSPT.				d. STREET ADDRESS 32 Bloomsbury Sq.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) WILLIAM W. MEEKINS		First Middle Last		4. DATE OF DEATH 2 6 1958		Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 15-1884		9. AGE (in years last birthday) 73 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City employee		10b. KIND OF BUSINESS OR INDUSTRY City employee		11. BIRTHPLACE (State or foreign country) Annapolis Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augustus Meekins				14. MOTHER'S MAIDEN NAME Martha Gray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Martha Wyatt Hewlett Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4344 DUE TO Heart Disease Conditions, if any, which gave rise to immediate cause (b) sudden (c), stating the underlying cause lost. DUE TO - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. L. Hewlett				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/6/58	
EXAMINER'S NAME (Type) E. L. Hewlett				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-9-58		22c. NAME OF CEMETERY OR CREMATORY Belcrest Cemt.		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons				ADDRESS Annapolis Md.		24a. REC'D BY REGISTRAR W. J. Smith	
				DATE FEB 10 58		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

BUREAU V. S.

FEB .

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

01486

1507

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINNIE Middle MILLER Last		4. DATE OF DEATH Month February Day 20 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 10, 1870
9. AGE (In years last birthday) 87 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Gehrde, Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT Mr Calvin L. Miller- Son- same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arterio Sclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 year 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1946 to Feb 20 1958 , that I last saw the deceased alive on Feb 19 1958 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward J. Skerritt M.D. 62-246-1115 Md		DATE SIGNED 2-20-58	
PHYSICIAN'S NAME (Type) Edward J. Skerritt MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-23-58	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR DATE FEB 25 58		24b. REGISTRAR'S SIGNATURE W. Beach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 20 1900

100-1000

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01487

Reg. Dist. No.

1508

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PASADENA		c. LENGTH OF STAY IN 1b 16 MO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7 BROOKVIEW RD. PASADENA MD.		d. STREET ADDRESS 7 BROOKVIEW	
3. NAME OF DECEASED (Type or print) WILLIAM RICHARD MOESSNER JR.		4. DATE OF DEATH FEB 7 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1912 JULY 8 1918
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRY SUPT.		10b. KIND OF BUSINESS OR INDUSTRY LAUNDRY	
11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM RICHARD MOSSNER		14. MOTHER'S MAIDEN NAME KATHLEEN MARLOWE DAYTONA BEACH FLA.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 262-014058	
17. INFORMANT WIFE		Address PASADENA, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE 155.3 DUE TO (b) CARCINOMA SIGMOID WITH METASTASIS (c) CACHEXIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEPATIC INSUFFICIENCY			INTERVAL BETWEEN ONSET AND DEATH 24 HRS 2 YRS 3 MO.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 1957 to FEB 7 1958 , that I last saw the deceased alive on FEB 6 1958 , and that death occurred at 4:15 A.M. from the causes and on the date stated above.			
SIGNATURE Arthur Lankford Jr.		ADDRESS (Street, city or town, state) Mountain Rd. Pasadena, Md.	
PHYSICIAN'S NAME (Type) ARTHUR LANKFORD JR.		ADDRESS MOUNTAIN RD. PASADENA MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF FEB. 10/58	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemo		22d. LOCATION (City, town, or county) (State) Baltimore MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Glen B. ...		24a. REC'D BY REGISTRAR DATE FEB 13 '58	
24b. REGISTRAR'S SIGNATURE ...			

MEDICAL CERTIFICATION

COMBAND V. B.

1958

DEAD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01488

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1509

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Front of 5420 Wasena Avenue				d. STREET ADDRESS 5420 Wasena Avenue			
3. NAME OF DECEASED (Type or print) First VIOLA Middle C. (MEYER) Last MYERS				4. DATE OF DEATH Month February Day 11 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 24-1908	
9. AGE (In years last birthday) 49 yrs		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 19 Min.		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.0 DUE TO Exposure secondary to Acute Alcoholism. Conditions, if any, which gave rise to immediate cause (b) 322.0 DUE TO Exposure secondary to Acute Alcoholism. (c) 322.0 DUE TO Exposure secondary to Acute Alcoholism.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 132.0							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Found on pavement in front of home.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 6:00 2/11 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In front of home		20f. (City or town) (County) (State) Brooklyn A. A. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Paul F. Guerin				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 2/11/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-14-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		22d. LOCATION (City, town, or county) (State) Brooklyn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mc Cully				ADDRESS Funeral Homes 130 E. Fortane			
24a. REC'D BY REGISTRAR Feb 13 1958				24b. REGISTRAR'S SIGNATURE Alberich			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1898

EDV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1458

CERTIFICATE OF DEATH

01489

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>32 Years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>			d. STREET ADDRESS <u>312 No. Glenn Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ELORY</u> Middle <u>WATSON</u> Last <u>O'CAIN</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>17</u> Year <u>19 58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-88</u>		9. AGE (In years last birthday) yrs. <u>69</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy Ret.</u>	11. BIRTHPLACE (State or foreign country) <u>So. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Lewis R. O'CAIN</u>			14. MOTHER'S MAIDEN NAME <u>Ella PENNY</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year, or dates of service) <u>WWI WWII</u>		16. SOCIAL SECURITY NO <u>- - - -</u>	17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Maryland</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LUNG ACESS with aspiration</u> <u>141.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RHABDOMYOSARCOMA base of tongue with metastasis</u> DUE TO (c) <u>CHRONIC PYLONEPHRITIS AND ARTERIOSCLEROSIS PERIPHERAL</u>					INTERVAL BETWEEN ONSET AND DEATH <u>approx. 4wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-20</u> , 19 <u>58</u> , to <u>2-17-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-17-</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Anna. Md.</u> DATE SIGNED <u>2-18-58</u>					
ACTUAL SIGNATURE <u>James W. Dinsmore</u> M.D.			PHYSICIAN'S NAME (Type) <u>J. W. DINSMORE LT MC USNR</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 21, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPKING FUNERAL HOME</u> ADDRESS <u>Annapolis, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>FEB 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Dinsmore</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB

751-151

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01490

1510

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 1		
3. NAME OF DECEASED (Type or print) First JAMES Middle PARKER Last			4. DATE OF DEATH Month February Day 26 Year 1958		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) 22 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Davidsonville Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas H. Parker			14. MOTHER'S MAIDEN NAME Martha Brown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, name unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Elizabeth A. Parker Davidsonville Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis 002 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause first. (c) </div>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial	20f. (City or town) Davidsonville	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/27/58	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL CREMATION OR REMOVAL (Specify) Burial	22b. DATE THEREOF 3-2-1958	22c. NAME OF CEMETERY OR CREMATORY Union Chapel		22d. LOCATION (City, town, or county) (State) Davidsonville Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese		ADDRESS #108 Wash. St. Annapolis Md		24a. REC'D BY REGISTRAR Feb 28 1958	24b. REGISTRAR'S SIGNATURE Art Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BONLAND V. S.

1958

DEAD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1459

CERTIFICATE OF DEATH

01491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Xtanza - Pasadena</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen. Hospital</u>		d. STREET ADDRESS <u>Rt. 2, Box 360</u>	
3. NAME OF DECEASED (Type or print) First <u>Maudie</u> Middle <u>Pemberton</u> Last <u></u>		4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-25-80</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Dandridge Pemberton</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-22-6870</u>	
17. INFORMANT <u>Mrs. Mary Belanger</u>		Address <u>Pasadena Beach, Pasadena, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular collapse</u> DUE TO (b) <u>Inanition</u> (c) <u>Pulmonary Tuberculosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>Not known</u> <u>Not known</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Undetermined in few hours seen in hospital</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>-</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>	
21. I certify that I attended the deceased from <u>Feb. 18, 5:45 PM 1958</u> , to <u>Feb. 18, 9:40 PM 1958</u> , that I last saw the deceased alive on <u>Feb. 18, 1958</u> , and that death occurred at <u>9:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Merton T. Waite</u>		ADDRESS (Street, city or town, state) <u>Cathedral & Dean Sts.</u>	
PHYSICIAN'S NAME (Type) <u>MERTON T. Waite</u>		DATE SIGNED <u>2-18-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 21, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 21 58</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Simon</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director, by the funeral director, and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

100

1511

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LINTHICUM</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X LINTHICUM</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>200 S. CAMP MEADE RD.</u>		d. STREET ADDRESS <u>200 S. CAMP MEADE RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NICHOLAS</u> Middle <u>A.</u> Last <u>PFEIFFER</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 1, 1868</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>NICHOLAS ADAM PFEIFFER</u>		14. MOTHER'S MAIDEN NAME <u>MARY METZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>MRS. AVERIL P. GARNER</u> Address <u>200 S. CAMP MEADE RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4200</u> <u>pneumonia</u> DUE TO (b) <u>intermediate Heart Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u> <u>10 hrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 27</u> , 19 <u>58</u> , to <u>Feb 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 27</u> , 19 <u>58</u> , and that death occurred at <u>10:45 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Milton Linthicum</u> M.D. <u>106 W. Maple Rd. Linticum A.A. Co. MD.</u>		DATE SIGNED <u>2/5/58</u>	
PHYSICIAN'S NAME (Type) <u>C. MILTON LINTHICUM, M.D., 106 W. MAPLE RD., A.A.CO. MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB. 6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LITKE FUNERAL DIR. 4111 EDMONDSON AVE.</u>		24a. REC'D BY REGISTRAR <u>DATE</u> 24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 6 1903

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

01493

SANN'S Nursing Home

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastport, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cecil-Rd.</u>		d. STREET ADDRESS <u>818 Bay Ridge Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> - Middle <u>L</u> Last <u>PHIPPS</u>		4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13-1883</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Robert S Price</u>		14. MOTHER'S MAIDEN NAME <u>Emma Avery</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary V. Sann L.P.N.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> 350x DUE TO <u>Pericardial Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-17-58</u> , 19 <u>58</u> , to <u>2-14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/31/58</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eustace H. Faubert</u> M.D.		DATE SIGNED <u>2/14/58</u>	
PHYSICIAN'S NAME (Type) <u>EUSTACE H. FAUBERT</u>		<u>John Burdick, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-17-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Sayla Sins</u> ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

13 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1460

CERTIFICATE OF DEATH

01494

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY A.A. CO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERNA PARK A.A. CO., MD.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FREDERICK Middle W. Last PIEHLER		4. DATE OF DEATH Month FEB. Day 26 Year 1958					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/1882	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY LIFE INSURANCE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME FRANK PIEHLER				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT MRS. JENNIE T. PIEHLER #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute dilatation of heart 422.1 DUE TO (b) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c) Chr. Congestive Heart Failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Pancreas with Metastasis to Liver & other organs				INTERVAL BETWEEN ONSET AND DEATH 10 min (?) Yes. 6 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 12 19 58 to Feb 26 19 58 that I last saw the deceased alive on Feb 26 19 58 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE MAURICE K. KAWANS M.D.				ADDRESS (Street, city or town, state) 31 SOUTHEAST AVE ANNAPOLIS, MD.			
PHYSICIAN'S NAME (Type) MAURICE K. KAWANS				DATE SIGNED 2/27/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/1/58		22c. NAME OF CEMETERY OR CREMATORY HILLCREST		22d. LOCATION (City, town, or county) (State) ANNAPOLIS, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR AND SONS				24a. REC'D BY REGISTRAR DATE 2/28/58		24b. REGISTRAR'S SIGNATURE Gov.	

MEDICAL CERTIFICATION

TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

U.S.

1958

73A

CERTIFICATE OF DEATH

01495

Reg. Dist. No.

1461

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn (Delmont)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>"Baby"</u> Middle <u>Girl</u> Last <u>Polacek</u>		4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 13 1958</u>
9. AGE (In years last birthday) yrs <u>10</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Polacek</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Henry Polacek</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>Placental insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pre-eclampsia</u> (c) <u>Unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fetal distress, umbilical</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Difficult birth delivery</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Joseph B. Shuckman</u> M.D.			
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 16 58</u>	24b. REGISTRAR'S SIGNATURE <u>U. S. Smith</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained for use in hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ROTHMAN V. S.

FEB

1962

1513

CERTIFICATE OF DEATH

01496

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Skidmore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Skidmore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Log Farm Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Porter</u> Middle <u>Porter</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cal</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitor</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>State Ark</u>	
12. BIRTHPLACE (State or foreign country) <u>Skidmore, Md.</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>James Porter</u>		15. MOTHER'S MAIDEN NAME <u>?</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (For use in unknown) <u>No</u> (If yes, give year or dates of service)		17. SOCIAL SECURITY NO. <u>?</u>	
18. INFORMANT <u>Charles Porter Jr.</u> Address <u>Skidmore, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Heart Disease</u> <u>420.0</u> DUE TO <u>with Enzymatic changes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO <u>?</u> (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-8-57</u> , 19 <u>57</u> , to <u>2-27-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-21-58</u> , 19 <u>58</u> , and that death occurred at <u>7:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u>		DATE SIGNED <u>2-28-58</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		ADDRESS (Street, city or town, state) <u>61 Cathedral St Skidmore, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-3-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Broad Neck</u>		22d. LOCATION (City, town, or county) (State) <u>Skidmore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese & Anna, Md.</u>		ADDRESS <u>?</u>	
24a. REC'D BY REGISTRAR <u>?</u>		24b. REGISTRAR'S SIGNATURE <u>?</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR NURSING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

CERTIFICATE OF DEATH

01497

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Anne Arundel General Hospital		d. STREET ADDRESS 131 West Street	
3. NAME OF DECEASED (Type or print) First Richardo Middle Priestley Last Priestley		4. DATE OF DEATH Month February Day 21 Year 1958	
5. SEX M.	6. COLOR OR RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 20, 1958
9. AGE (In years lost birthday) Newborn		IF UNDER 1 YEAR Months infant Days infant Hours infant Min. infant	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carlwell Priestley		14. MOTHER'S MAIDEN NAME Sylvia Marie Dorsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address 131 West St., Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia 761.0 DUE TO Intermittent Asphyxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Abusive Placenta DUE TO (c) 18 hrs. 2 mos. - 18 hr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Dr. Stuart Christhill, Jr. M.D.			
PHYSICIAN'S NAME (Type) Dr. Stuart Christhill, Jr. Franklin St., Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3-1-1958	Brewer Hall	Annapolis Md
23. FUNERAL DIRECTOR'S SIGNATURE William Keese		24a. REC'D BY REGISTRAR 108 Wash. St. Annapolis	
24b. REGISTRAR'S SIGNATURE William Keese		DATE FEB 28 '58	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1930

U. S. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01498

1463

1. PLACE OF DEATH a. COUNTY <u>Ad. Co. County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ad. Co. County</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>56 Clay Street</u>				d. STREET ADDRESS <u>56 Clay Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>Randall</u> Last <u></u>				4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cal.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-23-1892</u>	
9. AGE (In years last birthday) <u>65</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Merrick Randall</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-30-724</u>			
17. INFORMANT <u>Lucile Henderson</u>				Address <u>56 Clay St. Annapolis Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>Arteriosclerotic Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cardiovascular Disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Annapolis</u> (County) <u>Ad. Co.</u> (State) <u>Md.</u>				20g. (City or town) <u>Annapolis</u> (County) <u>Ad. Co.</u> (State) <u>Md.</u>			
21. I certify that I attended the deceased from <u>Feb 12 (1:30 AM)</u> 19 <u>58</u> , to <u>Feb 13 (4:30 AM)</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 12 (4:30 AM)</u> 19 <u>58</u> , and that death occurred at <u>4:30</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. R. Randall</u>				ADDRESS (Street, city or town, state) <u>110 - Clay St. Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>R. R. Randall</u>				DATE/SIGNED <u>2/13/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Burial Hill</u>		22d. LOCATION (City, town, or county) <u>Annapolis Md.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William R. H. 108 Wash. St. N. W. Md.</u>				24a. REC'D BY REGISTRAR <u>W. R. H.</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. H.</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01499

1514

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Severna Park</u>		c. LENGTH OF STAY IN 1b <u>3 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oak Lane Carlton Manor</u>				d. STREET ADDRESS <u>Same</u>			
3. NAME OF DECEASED (Type or print) <u>Bertha Mae Rhodes</u>				4. DATE OF DEATH <u>February 1st. 19 58</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/7/84</u>	
9. AGE (In years last birthday) <u>73 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fairstone, Pa.</u>			
13. FATHER'S NAME <u>James Greenleaf</u>				14. MOTHER'S MAIDEN NAME <u>Alice Friend</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Mr. Frank J. Rhodes (Husband)</u>			
17. INFORMANT <u>Mr. Frank J. Rhodes (Husband)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Probably aggravated by being submerged in</u> (c) <u>8 inches of water while taking a bath.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Found dead in the bath tub 8 inches of water.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Balto. 25 Md</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>2/1/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. 25 Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Hopping & KICKNEY, GLEN BURNIE, MD</u>				24a. REC'D BY REGISTRAR <u>FEB 4 58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

8 A 10

8907

03 APR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, this page should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1515

CERTIFICATE OF DEATH

01500

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>5mos, 27das.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Belle</u> Last <u>Richardson</u>		4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/26/02</u>
9. AGE (In years last birthday) <u>55</u> yrs		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>South Carolina</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Brannon</u>		14. MOTHER'S MAIDEN NAME <u>Priscilla Freshley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>-----</u>	
17. INFORMANT <u>Hospital Records</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>44 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal Failure</u> DUE TO (c) <u>Hypertensive Cardio-vascular Renal Disease</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right Hemiplegia due to Cardiovascular Accident</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	20f. (City or town) (County) (State) <u>-----</u>
21. I certify that I attended the deceased from <u>August 23, 1957</u> , to <u>February 19, 1958</u> , that I last saw the deceased alive on <u>February 19, 1958</u> , and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>2/20/58</u>			
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D.		PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-24-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial PK.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Randolph Collins</u>		ADDRESS <u>1412 E. PRESTON ST.</u>	
24a. REC'D BY REGISTRAR <u>-----</u>		24b. REGISTRAR'S SIGNATURE <u>-----</u>	
DATE <u>FEB 27 '58</u>			

BUREAU V. S.

FEB 27 1953

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 01501

1. PLACE OF DEATH a. COUNTY <u>Glen Burnie</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Conv. Home-Furnace Br. Rd.</u>		d. STREET ADDRESS <u>315 Zepplin Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richardson</u>		4. DATE OF DEATH Month Day Year <u>2</u> <u>9</u> <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. <u>2</u> <u>9</u> <u>4</u> <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cockeysville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Virginia Smith</u>		Address <u>320 Zepplin Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tubercular Pneumonia</u> DUE TO (c) <u>Hypertensive and vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 wks</u> <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 6, 1958</u> to <u>Feb 9, 1958</u> , that I last saw the deceased alive on <u>Feb 6, 1958</u> , and that death occurred at <u>10:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles R. Law</u>		ADDRESS (Street, city or town, state) <u>101 W. Zepplin Rd, Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>Charles R. Law</u>		DATE SIGNED <u>2/9/58</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-13-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	22d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		ADDRESS <u>802 Madison Avenue</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Aw. Smith</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 1 1938

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01502

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (WOODLAND BEACH) EDGEWATER				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAND BEACH, EDGEWATER			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FAIRFULL DRIVE				d. STREET ADDRESS FAIRFULL DRIVE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ROY WILLIAM RINKER				4. DATE OF DEATH Month Day Year FEBRUARY 21 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 20, 1896		9. AGE (In years last birthday) 61 yrs.	IF UNDER YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY Building construction		11. BIRTHPLACE (State or foreign country) Winchester, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. 224-10-8316		17. INFORMANT Wallace W. Ricker- Son- Edgewater, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 30 minutes 4 years						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Sylvia M. Lim M.D.				DATE SIGNED 2/23/58			
EXAMINER'S NAME (Type) Sylvia M. Lim MD				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 25, 1958		22c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery		22d. LOCATION (City, town, or county) (State) Winchester, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE HO PING FUNERAL HOME ADDRESS Annaolis, Md.				24a. REC'D BY REGISTRAR 2/25/58		24b. REGISTRAR'S SIGNATURE W. Ricker	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ROMAN V. S.

1000

1464

CERTIFICATE OF DEATH

01503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gova Road RFD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Smith</u> Last <u>Sahn</u>		4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-24-1874</u>
9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Warsaw Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Smith</u>		14. MOTHER'S MAIDEN NAME <u>Eva Noel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>M. Katherine Sahn</u>		Address <u>3024 W. Calvert St Apt E 1 Baltimore 18 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis generalisef</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS ALTPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>November 19 58</u> to <u>2-5-1958</u> , that I last saw the deceased alive on <u>2-4-1958</u> and that death occurred at <u>4 P M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 SHAW ST. ANNAPOLIS, MD.</u>			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		DATE SIGNED <u>2/6/58</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-7-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u> ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 10 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. B. Smith</u>

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 10 1950

RECEIVED

1465
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>W.A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>47 Larkin Street</u>		1. d. STREET ADDRESS <u>47 Larkin Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Scott</u> Last <u>Scott</u>		4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-5-1881</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Annapolis Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? Scott</u>		14. MOTHER'S MAIDEN NAME <u>? Boston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Margorie H. Parker 50 Larkin St.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Chronic Throat Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>332X</u> DUE TO <u>Chronic Throat Cancer</u> (c) <u>Chronic Throat Cancer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-25-58</u> 19 <u>58</u> to <u>2-26-58</u> 19 <u>58</u> , that I last saw the deceased alive on <u>2-25-58</u> 19 <u>58</u> , and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>A. H. Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>62 Cathedral St, Annapolis Md</u> DATE SIGNED <u>2-26-58</u>	
PHYSICIAN'S NAME (Type) <u>A. H. ALLEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-1-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese #108 Wash St Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>Feb 28 58</u> 24b. REGISTRAR'S SIGNATURE <u>William Reese</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 28 1953

BUREAU V. S.

1466

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) d. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>23 CORNHILL ST.</u>		d. STREET ADDRESS <u>23 CORNHILL ST.</u>	
3 NAME OF DECEASED (Type or print) First <u>F+T+A</u> Middle <u>B.</u> Last <u>SHAW</u>		4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HENRY WEAVER</u>		14. MOTHER'S MAIDEN NAME <u>"UNK"</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>PAUL H. SHAW</u> Address <u>#2</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) <u>UNKNOWN</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>IN AN ITION</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>DEC 1954</u> to <u>FEB 1958</u> , that I last saw the deceased alive on <u>6 FEB 1958</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southgate Ave</u> DATE SIGNED <u>4/8/58</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-10-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u>	22d. LOCATION (City, town, or county) (State) <u>GLEN BURNIE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 10 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Will Branch</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 could be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUROU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1467

CERTIFICATE OF DEATH

Reg. Dist. No.

01506

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>67 Collage Ave</u>		d. STREET ADDRESS <u>67 Collage Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Emma Rogers Sherbert</u>		4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-1870</u>
9. AGE (In years last birthday) <u>88</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A.Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Violetta Webster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Mrs Louis N. Phipps</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Vascular Failure</u> <u>450.0</u> DUE TO (b) <u>Uræmia (Coma)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>General Arterio Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>Several Days</u> <u>Several Yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>At</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 10</u> , 19 <u>58</u> , to <u>Feb 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 20</u> , 19 <u>58</u> , and that death occurred at <u>4:30</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Oliver Purvis</u> M.D.		ADDRESS (Street, city or town, state) <u>Annapolis Md</u>	
PHYSICIAN'S NAME (Type) <u>J. OLIVER PURVIS</u>		DATE SIGNED <u>2/21/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-23-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sherbert Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>Deale A.A.Co Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>FEB 24 1958</u>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

FEB 11 1958

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 2 Film 3226 2-28-58 et

01507

1518

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ADAMS</u>		STATE <u>MARYLAND</u>		COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Green Burnie</u>				TOWN <u>La Plata</u>		<u>087</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Plaza Mayor Univ. Home</u>				STREET ADDRESS (If rural give location) <u>---</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>PETER</u> (Middle) <u>SHORT</u> (Last) <u>SHORT</u>				Month <u>2</u> Day <u>15</u> Year <u>1958</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
<u>M</u>	<u>C</u>	<u>Widowed</u>		<u>58</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>FARMER</u>					<u>LAPLATA CHAS. CO. MD.</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JIM SHORT</u>				<u>MARY SHORT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<u>NO</u>			<u>---</u>				
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral - vascular accident</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriole arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1958</u> to <u>Feb 15</u>, 19<u>58</u>, that I last saw the deceased alive on <u>Feb 15</u>, 19<u>58</u>, and that death occurred at <u>5:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>John T. LEE</u>				DATE SIGNED <u>Feb 15 1958</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>2-22-58</u>		<u>MT Auburn</u>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
				<u>Charles R. Law</u>		<u>CHARLES R. LAW - 802 Madison Ave</u>	
DATE <u>FEB 24 1958</u>							

BUREAU V. S.

FEB 4 1958

RECEIVED

1519

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G Meade			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		
c. LENGTH OF STAY IN 1b 18hrs 35 min			d. STREET ADDRESS 800 5th St Laurel		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Michael Middle Shotola Last Shotola			4. DATE OF DEATH Month February Day 5 Year 19 58		
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 Jan 58		9. AGE (In years last birthday) yrs 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Donald Lee Shotola			14. MOTHER'S MAIDEN NAME Rosemaria Theresa Kotecki		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT (Father) Donald Lee Shotola, 800 5th St Laurel, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 4 Feb , 19 58 , to 5 Feb , 19 58 , that I last saw the deceased alive on 5 February , 19 58 , and that death occurred at 0530 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 5 Feb 58					
ACTUAL SIGNATURE Fred M Lafferty M.D.					
PHYSICIAN'S NAME (Type) FRED M LAFFERTY, CAPT MC			US ARMY HOSPITAL, FT MEADE, MD		
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial	22b. DATE THEREOF 2/6/58	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county)	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Earl B Wolberton Funeral Home, Inc			24a. REC'D BY REGISTRAR DATE 5 Feb 58		
ADDRESS 6366 - Belair Rd, Baltimore - 6, Md			24b. REGISTRAR'S SIGNATURE Wilbur H Downson		

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

1944

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01509

1520

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Arnold - R.F.D.</u>		<u>3 weeks</u>		TOWN <u>Arnold - R.F.D.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ruper Manor - Rt 1 - Box 897</u>				STREET ADDRESS (If rural give location) <u>Ruper Manor - Rt 1 - Box 397</u>			
3. NAME OF DECEASED (Type or Print) <u>Robert F. Kessler Specht</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 7 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct. 22 - 1878</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Specht</u>				14. MOTHER'S MAIDEN NAME <u>Arrelia Kessler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Ruth Fainall - Same as NO 2</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Arteriosclerosis</u>						2 Weeks	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Disease</u>						27 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-4-</u> , 19 <u>57</u> , to <u>2-7-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-2-8-</u> , 19 <u>58</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frederick M. Shipley</u>				ADDRESS (Street, city, town, state) <u>M.D. 636 College Ave Annapolis Md</u>		DATE SIGNED <u>2-10-58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 11 - 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
DATE <u>FEB 12 '58</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

U.S. DEPT. OF JUSTICE

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1521 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01510

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Severn</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Annapolis - Telegraph Hds.</u>				d. STREET ADDRESS <u>Annapolis - Telegraph Hds.</u>			
3. NAME OF DECEASED (Type or print) First <u>ALLEN</u> Middle <u>C.</u> Last <u>STEVENSON</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1897</u>	9. AGE (in years last birthday) <u>60</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Glen Dale, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Allen Stevenson</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>212 01 4027</u>		17. INFORMANT <u>Mr. Spencer Stevenson</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Farbert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2/27/58</u>			
EXAMINER'S NAME (Type) <u>Gustave H. Farbert M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Dale, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glen Dale, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>DATE FEB 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. E. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

ROBERT V. S.

1937

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1522

CERTIFICATE OF DEATH

01511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>				c. LENGTH OF STAY IN 1b <u>4ys, 2mos, 20ds</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3 Yrs / 4</u>			
f. STREET ADDRESS <u>1011 Spring Street</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edward</u> Last <u>Stokes</u>				4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/7</u>	
9. AGE (In years last birthday) <u>75?</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stevodore</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>James Stokes</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Thomas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decubitus Ulcers</u>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) <u>Generalized Arteriosclerosis</u>							
DUE TO							
(c) <u>C. N. S. Syphilis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<u>Chronic Brain Syndrome associated with Generalized Arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m. -----				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>January 13, 1957</u> to <u>February 24, 1958</u> , that I last saw the deceased alive on <u>February 24, 1958</u> and that death occurred at <u>4:25 P.M.</u> from the causes and on the date stated above							
ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>2/25/58</u>							
PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissmann, M.D.</u> <u>Crownsville State Hospital, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-1-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Calvary Cem</u>		22d. LOCATION (City, town, or county) (State) <u>C.A.C. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rayner Sanders</u>				24a. REC'D BY REGISTRAR <u>MAR 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Quinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4

BUREAU V. S.

MAR 6 1938

RECEIVED

1523

CERTIFICATE OF DEATH

Reg. Dist. No.

01513

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Heights</u>		c. LENGTH OF STAY IN 1b <u>2 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4902 Kramme Ave Balto 25</u>		e. STREET ADDRESS <u>1115 River Side Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>C.</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12 1895</u>
9. AGE (In years last birthday) yrs <u>62</u>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Harvey</u>	
14. MOTHER'S MAIDEN NAME <u>Laura Ward</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <u>19-30-4602</u>		17. INFORMANT Address <u>Balto 21 Md</u> <u>Mrs. Mary V Michael 11406 Waterford Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinoma</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 14</u> , 19 <u>58</u> , to <u>Feb 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 14</u> , 19 <u>58</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Oscar I. Vaskuez M.D.</u>		ADDRESS (Street, city or town, state) <u>1213 Light St. Balto 30 Md</u>	
DATE SIGNED <u>2/15/58</u>		DATE SIGNED <u>2/15/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mon Feb 18 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn A A CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Griffith Evans</u>		ADDRESS <u>1400 Charles St</u>	
24a. REC'D BY REGISTRAR <u>Feb 18 58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB

1911

1468

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Thomas</u> Last		4. DATE OF DEATH Month <u>2-</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-18-1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR: Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reporter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>Davidsonville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Emanuel Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Georganna Tongue</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not; or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-36-240</u>	
17. INFORMANT <u>Engenia Thomas Davidsonville Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 days</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-3-58</u> , 19 <u>58</u> , to <u>2-4-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-4-58</u> , 19 <u>58</u> , and that death occurred at <u>6:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. T. Allen</u>		DATE SIGNED <u>6-2-58</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		ADDRESS (Street, city or town, state) <u>Annapolis Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-9-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	22d. LOCATION (City, town, or county) (state) <u>Davidsonville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese #108 Wash St. Annapolis Md.</u>		24a. REC'D BY REGISTRAR <u>W. T. Allen</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR A N D I N G P H Y S I C I A N : The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01515

1524

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. LENGTH OF STAY in lb <u>4ys, 10mos, 26d</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>				d. STREET ADDRESS <u>R. F. D. Box 29</u>			
3. NAME OF DECEASED (Type or print) First <u>Zilphy</u> Middle <u>Ellen</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>5/30/1867</u>		9. AGE (In years last birthday) <u>90?</u> yrs		IF UNDER 1 YEAR Months _____ Days _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Robert Ward</u>			
14. MOTHER'S MAIDEN NAME <u>Mervia</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>-----</u>				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular Disease</u> DUE TO (c) <u>Arteriosclerosis</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Senile Brain Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>-----</u>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>		20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19____					
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>					
20f. (City or town) <u>-----</u>		(County) _____ (State) _____					
21. I certify that I attended the deceased from <u>November 2, 1956</u> to <u>February 26, 1958</u> , that I last saw the deceased alive on <u>February 26, 1958</u> , and that death occurred at <u>7:40 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>2/27/58</u>							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D.		PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u> <u>Crownsville State Hospital, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-6-58</u>		22b. DATE THEREOF <u>3-6-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>			
22d. LOCATION (City, town, or county) <u>Washington</u>		(State) <u>DC</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. G. 901-3-5154</u>		ADDRESS <u>Washington DC</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '58</u>			
24b. REGISTRAR'S SIGNATURE <u>-----</u>		24c. REGISTRAR'S SIGNATURE <u>-----</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: This certificate is to be retained by the hospital or funeral home. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or funeral home. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAR 6 1964

J b, ne hospital or offending physician.
RECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1469

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>N. H.</i> b. COUNTY <i>Hillsboro</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>115 Vicki Parkway</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ellen</i> Middle <i>Martin</i> Last <i>Thompson</i>		4. DATE OF DEATH Month <i>2</i> Day <i>7</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-27-1885</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Manchester N. H.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>John Martin</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Mrs Robert E. Sundius</i>		Address <i>115 Vicki Parkway Annapolis Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4-52.1</i> DUE TO <i>Cardiovascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>not</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 1 - 1958</i> to <i>Feb 7 - 1958</i> , that I last saw the deceased alive on <i>2/7/58</i> , 19 <i>58</i> , and that death occurred at <i>7</i> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <i>2/7/58</i>	
ACTUAL SIGNATURE <i>E. L. Herbert</i>		M.D. <i>Amphibolus</i>	
PHYSICIAN'S NAME (Type) <i>E. L. Herbert</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>General</i>	<i>2-7-58</i>	<i>St. Joseph's Cemetery</i>	<i>Manchester N. H.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Saylor Sr.</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 10 1958</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>Edw. Souch</i>	

MEDICAL CERTIFICATION

RECEIVED

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RECEIVED

1525

CERTIFICATE OF DEATH

Reg. Dist. No.

01517

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park				c. LENGTH OF STAY IN 1b 30yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 Seventh Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Tomally Tobiason Thompson				4. DATE OF DEATH Month Day Year February 21 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1881	9. AGE (In years last birthday) yrs 76	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Jacob Tobiason				14. MOTHER'S MAIDEN NAME Anna Nielson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Address Miss Judith Thompson 108 Seventh Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) Coronary artery disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of uterus & metastases						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/1 , 19 57 , to 2/20 , 19 58 , that I last saw the deceased alive on 2/21 , 19 58 , and that death occurred at 7 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Morton M. Gieger		M. D. 5010A Ritchie Highway		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 24, 1958	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Ritchie Hwy., A. A. CO. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS George J. Stone 4001 Ritchie HWY.				24a. REC'D BY REGISTRAR DATE FEB 25 '58		24b. REGISTRAR'S SIGNATURE Alfred...	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 14 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

8

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **01518**

1526

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission.) a. STATE MARYLAND b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN lb 10 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Vincent's Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
				d. STREET ADDRESS 370 Glen Burnie Road			
				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Vogel Last W. J.				4. DATE OF DEATH Month February Day 16 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1868	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months 00 Days 00 Hours 00 Min. 00		IF UNDER 24 HRS Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber (ret)		10b. KIND OF BUSINESS OR INDUSTRY own business		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Vogel				14. MOTHER'S MAIDEN NAME William			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) //////		16. SOCIAL SECURITY NO. //////		17. INFORMANT Charles Vogel		Address St. Vincent's Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 10 1/2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o m 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1952 , 19 52 , to Feb. 16, 1958 , that I last saw the deceased alive on Feb. 14, 1958 , and that death occurred at 1:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Gustave H. Faubert M.D. _____							
PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D. Glen Burnie, Maryland 2/16/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/58		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek				24a. REC'D BY REGISTRAR Feb 20 1958		24b. REGISTRAR'S SIGNATURE W. J. ...	
ADDRESS 3331 Brehms Lane							

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1953

103

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1527

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Pasadena</u>		c. LENGTH OF STAY IN 1b <u>8 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 9 Box 100</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen Wells</u>				4 DATE OF DEATH <u>February 1st.</u> <u>19 58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/8/11</u>	9 AGE (in years last birthday) <u>46</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Hancock County, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles Williams</u>			14 MOTHER'S MAIDEN NAME <u>Mollie Lane</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17 INFORMANT <u>Theophilus Wells (husband)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>General Asthenia due to mental troubles.</u>							
77.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) DUE TO							
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>Due to mental troubles deceased would go days and months without food.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/1/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 4-1958</u>		<u>Glen Haven Cemetery</u>		<u>Glen Burnie</u> <u>md.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>L. D. Singleton</u>				ADDRESS <u>Glen Burnie, md.</u>		24a. REC'D BY REGISTRAR <u>FEB 1 5 58</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>			

DEPT. OF AGRICULTURE

FEB 1 1909

U.S.

MEDICAL CERTIFICATION

VS A1 (4)
15M 9:55

U. S. AIR FORCE

1. 1. 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01521

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade c. LENGTH OF STAY IN 1b 1528 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G Meade d. STREET ADDRESS Quarters 4541, English Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IDA Middle M Last WILLARD		4. DATE OF DEATH Month February Day 5 Year 19 58	
5. SEX Female	6. COLOR OR RACE Can	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 February 1880
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR: Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Frank Prevast		14. MOTHER'S MAIDEN NAME Unknown Agnes Sawyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Son: Paul S. Willard		Address Quarters 4541, English Avenue, Fort George G Meade, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-vascular Thrombosis DUE TO (b) Cerebro-vascular Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 20 days		INTERVAL BETWEEN ONSET AND DEATH 20 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 Jan., 1958 , to 5 Feb. , 19 58 , that I last saw the deceased alive on 5 Feb. , 19 58 , and that death occurred at 3:25 P.M. , from the causes and on the date stated above			
ACTUAL SIGNATURE John L. Robertson		ADDRESS (Street, city or town, state) U. S. ARMY HOSPITAL, FT MEADE, MD	
PHYSICIAN'S NAME (Type) JOHN L. ROBERTSON, CAPT, MC		DATE SIGNED 5 Feb 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2/7/58	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crem.		22d. LOCATION (City, town, or county) (State) Calmar Manor, Md	
23. FUNERAL DIRECTOR'S SIGNATURE He With Cavalahan, Laurel, Md		24a. REC'D BY REGISTRAR WILBUR H DOWNS, JR. CAPT,	
ADDRESS Laurel, Md		DATE 5 Feb 58	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 10 1973

RECEIVED

RECEIVED

CERTIFICATE OF DEATH

1529

Reg. Dist. No. 01522

1. PLACE OF DEATH a. COUNTY ANNIE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARLEY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARLEY MARLEY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1. d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AGATHA Middle L. WILLIAMS Last		4. DATE OF DEATH FEB 17 1958	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JAN 28, 1937
9. AGE (In years) 21		10. IF UNDER 1 YEAR: Months 1 Days 17 Hours 17 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE AT HOME		10b. KIND OF BUSINESS OR INDUSTRY JACOBSVILLE, MD	
11. BIRTHPLACE (State or foreign country) U. S. A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOSEPH BAKER		14. MOTHER'S MAIDEN NAME MARTHA SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO ---	
17. INFORMANT MRS LOLA HINES CEDAR H. LANE		Address 207	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary edema DUE TO Cardiac decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus, mild		INTERVAL BETWEEN ONSET AND DEATH 1 hour 3 months 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 13, 1957 , to Feb 17, 1958 , that I last saw the deceased alive on Feb 14, 1958 , and that death occurred at 8:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. M. McLaughlin M.D.		ADDRESS (Street, city or town, state) Pasadena, Md. DATE SIGNED Feb 18, 1958	
NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB 21 '58	
22c. NAME OF CEMETERY OR CREMATORY MTCAL CEM		22d. LOCATION (City, town, or county) (State) BROOKLAND AA CO MD	
23. FUNERAL DIRECTOR'S SIGNATURE ELROY D WILSON		ADDRESS 1000 BRANTLEY AVE	
24. REC'D BY REGISTRAR FEB 27 '58		24b. REGISTRAR'S SIGNATURE W. J. Beach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
U. S. BUREAU

FEB 27 1963

RECEIVED
U. S. BUREAU

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be attached with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1530

CERTIFICATE OF DEATH

01523

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>5 mos. 2 days</u>		d. STREET ADDRESS <u>1315 Spring Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>R.</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>80?</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>August 24, 1957</u> to <u>February 22, 1958</u> , that I last saw the deceased alive on <u>February 22, 1958</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ludwig Benedict</u>		ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Ludwig Benedict, M. D.</u>		DATE SIGNED <u>2/25/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-28-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Cedar Hill Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dolphus Halstead</u>		ADDRESS <u>918 Wind Hill</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

BUREAU V. S.

FEB 1953

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

01524

1471

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>W. H.</u> Middle <u>Wilson</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Emily Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Altie Harris</u>	
17. INFORMANT <u>15 Sunnyside Ave. Wash. D.C.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aneurysm of aorta & erosion into</u> <u>022X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Fracture giving pneumonia</u> DUE TO <u>Syphilis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 Wk.</u> <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1958</u> Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-10-58</u> 19 <u>58</u> to <u>2-11-58</u> 19 <u>58</u> , that I last saw the deceased alive on <u>2-11-58</u> , 19 <u>58</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u>		ADDRESS (Street, city or town, state) <u>13 College Ave</u> DATE SIGNED <u>2-14-58</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		<u>Annapolis Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-15-58</u>	<u>Montgomery Chapel</u>	<u>Hyattsville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keeser</u>		ADDRESS <u>108 Wash. St. Annapolis Md</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>FEB 27 '58</u>		<u>Aut.</u>	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 could be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

BUREAU V. S.
FEB 27 1939

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Elevation MD.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Peter F. Zeman</u>		4. DATE OF DEATH <u>2-5-58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12 1883</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker</u>		9b. AGE (In years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Monitor Comptrolite</u>	
11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Zeman</u>		14. MOTHER'S MAIDEN NAME <u>Marie (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-5927</u>	
17. INFORMANT <u>Son, Stephen F. Zeman</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Optic Atrophy (bilateral)</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , to <u>1958</u> , that I last saw the deceased alive on <u>Jan 12</u> , 19 <u>57</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		<u>Severna Park Md 2-5-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		<u>Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/8/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Singler</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. FEE D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE <u>W. J. French</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR **ENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is mostly blank with some faint, illegible handwriting.

BUREAU V. R.

FEB 10 1938

RECEIVED